Amendment of the whole
in committee. 7/5/06

FILE NO. 051919

ORDINANCE NO.

[San Francisco Health Care Security Ordinance]

Ordinance amending the San Francisco Administrative Code to add Chapter 14, Sections 14.1 through 14.8, to provide health care security for San Francisco residents by creating a public health access program for the uninsured, requiring employer paid health expenditures, identifying options for how an employer may make such expenditures, creating an advisory health access working group, and setting an operative date.

Note: Additions are *single-underline italics Times New Roman*; deletions are ~~*strikethrough italics Times New Roman*~~.
Board amendment additions are double underlined.
Board amendment deletions are ~~strikethrough normal~~

Be it ordained by the People of the City and County of San Francisco:

Section 1. **Declaration of legislative findings and intent.** All San Francisco residents should have quality, affordable health care. Currently, approximately 82,000 adult San Francisco residents are uninsured, even though more than half of those individuals are employed. San Francisco taxpayers bear the cost of paying for emergency room visits and other unnecessarily expensive health care for the uninsured. By establishing a Health Access Program for uninsured San Francisco residents with an emphasis on preventive care and by requiring businesses to make reasonable health care expenditures on behalf of their employees depending on the businesses' ability to pay, the burden on San Francisco taxpayers for providing health care for the uninsured can be reduced. At the same time, San Francisco can offer uninsured individuals the choice to enroll in a system that provides quality health care for an affordable price and offer employers the choice to enroll their employees in that system. San Francisco also has a vital interest in preventing a "race to the bottom" in which employers stop paying for employee health care to remain competitive and instead shift those costs to San Francisco taxpayers.

Section 2. The San Francisco Administrative Code is hereby amended by adding Chapter 14, Sections 14.1 through 14.8, to read as follows:

SEC. 14.1. SHORT TITLE; DEFINITIONS.

*(a) **Short title.** This Chapter shall be known and may be cited as the "San Francisco Health Care Security Ordinance."*

*(b) **Definitions.** For purposes of this Chapter, the following terms shall have the following meanings:*

(1) "City" means the City and County of San Francisco.

(2) "Covered employee" means any person who works in the City where such person qualifies as an employee entitled to payment of a minimum wage from an employer under the Minimum Wage Ordinance as provided under Chapter 12R of the San Francisco Administrative Code and has performed work for compensation for his or her employer for ninety (90) days, provided, however, that the term "employee" shall not include persons who are managerial, supervisorial, or confidential employees, unless such employees earn annually under $72,450 or in 2007 and for subsequent years, the figure as set by the administering agency, and shall not include those persons who are eligible to receive benefits under Medicare or the Civilian Health and Medical Program Uniformed Services (CHAMPUS). Nor shall "covered employees" include those persons who are "covered employees" as defined in Section 12Q.2.9 of the Health Care Accountability Ordinance, Chapter 12Q of the San Francisco Administrative Code, if the employer meets the requirements set forth in Section 12Q.3 for those employees. Nor shall "covered employees" include those persons who are employed by a nonprofit corporation for up to one year as trainees in a bona fide training program consistent with Federal law, which training program enables the trainee to advance into a permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee.

(3) "Covered employer" means any medium-sized or large business as defined below engaging in business within the City that is required to obtain a valid San Francisco business registration

certificate from the San Francisco Tax Collector's office or, in the case of a nonprofit corporation, a business with a minimum of fifty (50) covered employees. Small businesses are not "covered employers" and are exempt from the health care spending requirements under Section 14.3.

(4) "Employer" means an employing unit as defined in Section 135 of the California Unemployment Insurance Code or any person defined in Section 18 of the California Labor Code. "Employer" shall include all members of a "controlled group of corporations" as defined in Section 1563(a) of the United States Internal Revenue Code, except that "more than 50 percent" shall be substituted for "at least 80 percent" wherever such term appears in Section 1563(a)(1) of the Internal Revenue Code and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code.

(5) "Health Access Program" means a San Francisco Department of Public Health program to provide health care for uninsured San Francisco residents.

(6) "Health Access Program participant" means any uninsured San Francisco resident, regardless of employment or immigration status or pre-existing condition, who is enrolled by his or her employer or who enrolls as an individual in the Health Access Program under the terms established by the Department of Public Health.

(7) "Health care expenditure" means any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees, including, but not limited to (a) contributions by such employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income; (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services; (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees; (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and (e) payments by a covered employer to the City to fund the Health Access Program for uninsured San Francisco residents, including employees.

Notwithstanding any other provision of this subsection, "health care expenditure" shall not include any payment made directly or indirectly for workers' compensation or Medicare benefits.

(8) "Health care expenditure rate" means the amount of health care expenditure that a covered employer shall be required to make for each hour paid for each of its covered employees each quarter. The "health care expenditure rate" shall be determined based on the "average contribution" for a full-time employee to the City Health Service System pursuant to Section A8.423 of the San Francisco Charter based on the annual ten county survey amount for the applicable fiscal year, with such average contribution prorated on an hourly basis by dividing the monthly average contribution by one hundred seventy two (172) (the number of hours worked in a month by a full-time employee). The "health care expenditure rate" shall be seventy five percent (75%) of the preceding hourly average contribution for large businesses and fifty percent (50%) for medium-sized businesses.

(9) "Health care services" means medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses.

(10) "Hour paid" or "hours paid" means a work hour or work hours for which a person is paid wages or is entitled to be paid wages for work performed within the City, including paid vacation hours and paid sick leave hours. For salaried persons, "hours paid" shall be calculated based on a 40-hour work week for a full-time employee.

(11) "Large business" means an employer for which an average of one hundred (100) or more covered employees per week perform work for compensation during a quarter.

(12) "Medium-sized business" means an employer for which an average of between twenty (20) and ninety nine (99) covered employees per week perform work for compensation during a quarter.

(13) "Person" means any natural person, corporation, sole proprietorship, partnership, association, joint venture, limited liability company, or other legal entity.

(14) "Required health care expenditure" means the total health care expenditure that a covered employer is required to make every quarter for all its covered employees.

(15) "Small business" means an employer for which an average of fewer than twenty (20) covered employees per week perform work for compensation during a quarter.

SEC. 14.2. SAN FRANCISCO HEALTH ACCESS PROGRAM.

(a) The San Francisco Department of Public Health shall administer the Health Access Program. Under the Health Access Program, uninsured San Francisco residents may obtain health care from a network consisting of San Francisco General Hospital and the Department of Public Health's clinics, and other community non-profit and private providers that meet the program's quality and other criteria for participation. The Health Access Program is not an insurance plan for Health Access Program participants.

(b) The Department of Public Health shall coordinate with a third party vendor to administer program operations, including basic customer services, enrollment, tracking service utilization, billing, and communication with the participants.

(c) The Health Access Program shall be open to uninsured San Francisco residents, regardless of employment status. Eligibility criteria shall be established by the Department of Public Health, but no person shall be excluded from the Health Access Program based on a pre-existing condition. Participants may be enrolled by their employers or may enroll themselves as individuals, with the terms of enrollment to be determined pursuant to Section 14.4(a).

(d) The Health Access Program may be funded from a variety of sources, including payments from covered employers pursuant to Section 14.3, from individuals, and from the City. Funding from the City shall prioritize services for low and moderate income persons, with costs based on the Health Access Program participant's ability to pay. Funding from the City shall subsidize employee enrollment by medium-sized and small businesses.

(e) The Health Access Program shall use the "Medical Home" model in which a primary care physician, nurse practitioner, or physician assistant develop and direct a plan of care for each Health Access Program participant, coordinate referrals for testing and specialty services, and monitor management of chronic conditions and diseases. The Health Access Program shall assign each Health Access Program participant to a primary care physician, nurse practitioner, or physician assistant.

(f) The Health Access Program shall provide medical services with an emphasis on wellness, preventive care and innovative service delivery. The Program shall provide medical services for the prevention, diagnosis, and treatment of medical conditions, excluding vision, dental, infertility, cosmetic, and outpatient mental health services. The Department of Public Health may further define the services to be provided, except that such services must, at a minimum, include: professional medical services by doctors, nurse practitioners, physician assistants, and other licensed health care providers, including preventive, primary, diagnostic and specialty services; inpatient and outpatient hospital services, including acute inpatient mental health services; diagnostic and laboratory services, including therapeutic radiological services; prescription drugs, excluding drugs for excluded services; home health care; and emergency care provided in San Francisco by contracted providers, including emergency medical transportation if needed.

(g) The Health Access Program shall offer the opportunity for employers to enroll their employees and for individual enrollment by July 1, 2007.

SEC. 14.3. REQUIRED HEALTH CARE EXPENDITURES.

*(a) **Required Expenditures.** Covered employers shall make required health care expenditures on behalf of their covered employees each quarter. The City Controller shall maintain any required health care expenditures made by an employer to the City separate and apart from general funds and limit use of the expenditures to the Health Access Program. The required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours paid for all of its covered employees during the quarter (including only hours starting on the first day of the calendar month following ninety (90) calendar days after a covered employee's date of hire) by the applicable health care expenditure rate. In determining whether a covered employer has made its required health care expenditures, payments to or on behalf of a covered employee shall not be considered if they exceed the following amount: the number of hours paid for the covered employee during the quarter multiplied by the applicable health care expenditure rate. The City's Office of Labor Standards Enforcement (OLSE) shall enforce the health expenditure requirements under this Section.*

*(b) **Additional Employer Responsibilities.** A covered employer shall: (i) maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year, and allow OLSE reasonable access to such records, provided, however, that covered employers shall not be required to maintain such records in any particular form; and (ii) provide a report to the administering OLSE, or the OLSE's designee, on an annual basis containing such other information as OLSE shall require, but OLSE may not require an employer to provide information in violation of State or federal privacy laws. Where an employer does not maintain or retain adequate records documenting the health expenditures made, or does not allow OLSE reasonable access to such records, it shall be presumed that the employer did not make the required health expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise. The Office of Treasurer and Tax Collector shall have the authority to provide any and all information to OLSE necessary to fulfill the OLSE's responsibilities as the enforcing agency under this Ordinance. With regard to all such information provided by the Office of Treasurer and Tax Collector, OLSE shall be subject to the confidentiality provisions of subsection (a) of Section 6.22-1 of the San Francisco Business and Tax Regulations Code.*

SEC. 14.4 ADMINISTRATION AND ENFORCEMENT.

(a) The Department of Public Health shall develop and promulgate rules to govern the operation of the Health Access Program. The OLSE shall develop and promulgate rules to provide for the enforcement of the obligations of employers under this Chapter. The rules shall also establish procedures for covered employers to maintain accurate records of health care expenditures and required health care expenditures and provide a report to the City without requiring any disclosures of information that would violate state or federal privacy laws. The rules shall further establish procedures for providing employers notice that they may have violated this Chapter, a right to respond to the notice, a procedure for notification of the final determination of a violation, and an appeal procedure before a hearing officer appointed by the City Controller. The sole means of review of the hearing officer's decision shall be by filing in the San Francisco Superior Court a petition for a writ of

mandate under Section 1094.5 of the California Code of Civil Procedure. No rules shall be adopted finally until after a public hearing.

(c) During implementation of this Chapter and on an ongoing basis thereafter, the City shall maintain an education and advice program to assist employers with meeting the requirements of this Chapter.

(d) Any employer that reduces the number of covered employees below the number that would have resulted in the employer being considered a "covered employer," or below the number that would have resulted in the employer being considered a medium-sized or large business, shall demonstrate that such reduction was not done for the purpose of evading the obligations of this Chapter or shall be in violation of the Chapter.

(e) It shall be unlawful for any employer or covered employer to deprive or threaten to deprive any person of employment, take or threaten to take any reprisal or retaliatory action against any person, or directly or indirectly intimidate, threaten, coerce, command or influence or attempt to intimidate, threaten, coerce, command or influence any person because such person has cooperated or otherwise participated in an action to enforce, inquire about, or inform others about the requirements of this Chapter. Taking adverse action against a person within ninety (90) days of the person's exercise of rights protected under this Chapter shall raise a rebuttable presumption of having done so in retaliation for the exercise of such rights.

(f) The City shall enforce the obligations of employers and covered employers under this Chapter, and may impose administrative penalties upon employers and covered employers who violate this Chapter, including the requirements that businesses allow the City reasonable access to records of health expenditures, as follows: the amount of up to one-and-one-half times the total expenditures that a covered employer failed to make plus simple annual interest of up to ten (10) percent from the date payment should have been made.

(g) The City Controller shall report on implementation of the Health Access Program, including participation rates, any effect on services provided by the Department of Public Health, and costs of providing services to Health Access Program participants, and on the economic impact of this Chapter, to the Board of Supervisors on a quarterly basis through the end of 2009 and on an annual

basis thereafter. The City Controller shall also report within sixty (60) days after any significant event affecting the implementation of this Chapter, in which case the Board of Supervisors shall hold a hearing within thirty (30) days of receiving the report to consider responsive action.

(h) The Director of Public Health shall convene an advisory Health Access Working Group to provide the Department of Public Health and the Health Access Program with expert consultation and direction, with input on members from the Mayor and the Board of Supervisors. The Health Access Working Group shall be advisory in nature and may provide the Health Access Program with input on matters including: setting membership rates; designing the range of benefits and health care services for participants; and researching utilization, actuaries, and costs.

(i) The Department of Public Health and the OLSE shall report to the Board of Supervisors by January 31, 2007, on the development of rules for the Health Access Program and for the enforcement and administration of the employer obligations under this Chapter. The Board of Supervisors shall hold a hearing on the proposed rules to ensure that participants in the Health Access Program shall have access to high quality and culturally competent services.

SEC. 14.5. SEVERABILITY.

If any section, subsection, clause, phrase, or portion of this Chapter is for any reason held invalid or unconstitutional by any court or federal or state agency of competent jurisdiction, such portion shall be deemed a separate, distinct and independent provision and such holding shall not affect the validity of the remaining portions thereof. To this end, the provisions of this ordinance shall be deemed severable.

SEC.14.6. PREEMPTION.

Nothing in this Chapter shall be interpreted or applied so as to create any power, duty or obligation in conflict with, or preempted by, any federal or state law.

SEC.14.7. GENERAL WELFARE.

By this Chapter, the City is assuming an undertaking only to promote the general welfare and otherwise satisfy its obligations to provide health care under applicable law. This Chapter should in no way be construed as an expansion of the City's existing obligations to provide health care under state and federal law, and the City shall set all necessary criteria for enrollment consistent with its legal obligations. The City is not assuming, nor is it imposing on its officers and employees, an obligation for breach of which it is liable in money damages to any person who claims that such breach proximately caused injury. To the fullest extent permitted by law, the City shall assume no liability whatsoever. To the fullest extent permitted by law, any actions taken by a public officer or employee under the provisions of this Chapter shall not become a personal liability of any public officer or employee of the City.

SEC. 14.8. OPERATIVE DATE.

This Chapter shall become operative in three phases. The day this Chapter becomes effective, implementation of the Chapter shall commence. The Health Access Program and any requirements on medium-sized or large businesses with fifty (50) or more covered employees shall become operative on July 1, 2007. Any requirements on medium-sized businesses with twenty (20) or more covered employees shall become operative on January 1, 2008. This Chapter is intended to have prospective effect only.

APPROVED AS TO FORM:
DENNIS J. HERRERA, City Attorney

By: _____
ALEETA M. VAN RUNKLE

FILE NO.

LEGISLATIVE DIGEST

[San Francisco Health Care Security Ordinance]

Ordinance amending the San Francisco Administrative Code to add Chapter 14, Sections 14.1 through 14.8, to provide health care security for San Francisco residents by creating a public health access program for the uninsured, requiring employer paid health expenditures, identifying options for how an employer may make such expenditures, creating an advisory health access working group, and setting an operative date.

Existing Law

Existing law does not require that licensed businesses operating within San Francisco make health care expenditures on behalf of their employees. Local law does require that certain City contractors and lessors of City land comply with the Health Care Accountability Ordinance, Chapter 12Q of the Administrative Code, by choosing to pay a fee to the City to offset the cost of the City's provision of health care to the uninsured and underinsured populations, or by providing health care coverage to covered employees.

There are no existing local provisions on the Health Access Program.

Amendments to Current Law

The proposed measure entitled the "San Francisco Health Care Security Ordinance" will amend the San Francisco Administrative Code by adding Sections 14.1 through 14.8. The measure combines the proposed legislation creating the Health Access Program with the proposed Worker Health Care Security Ordinance.

A. The Health Access Program

The San Francisco Health Care Security Ordinance creates a public health program to provide a set of health benefits for uninsured San Franciscans. The San Francisco Department of Public Health will create and oversee the Program, which be called the San Francisco Health Access Program. The Program is not intended to serve as an insurance plan for participants. Under the Program, uninsured San Francisco residents may obtain medical care including, but not limited to, services in the areas of preventive, primary, and specialty care, as well as urgent and emergency care, from a network consisting of San Francisco General Hospital, the Department of Public Health's clinics, and community non-profit providers.

The Health Access Program will be open to uninsured San Francisco residents, regardless of employment or immigration status, who are otherwise eligible for services. No eligible participant shall be excluded from the Program based on a pre-existing condition.

The Program will provide participants with medical care, with an emphasis on wellness and preventative care. The available benefits may include laboratory, inpatient hospitalization, x-ray, elective surgery, and pharmaceuticals. All participants shall be eligible for the same benefits and health care services.

The Program may be funded from a variety of sources, including payments from participating employers that are satisfying the health expenditure requirement, individuals, and the City and County of San Francisco. City funding shall prioritize Program services for low income participants, and shall subsidize where possible, participation by businesses with fewer than one hundred (100) employees.

A third-party vendor, in coordination with the Department of Public Health, will administer program operations, including basic customer services, enrollment, tracking service utilizations, billing, and communication with the participants.

Under the proposed legislation, the Director of Public Health shall convene an advisory Health Access Working Group to provide the Department of Public Health and the Health Access Program with expert consultation and direction. The Mayor and Board of Supervisors shall have input on members selected for the Working Group. The Health Access Working Group shall be advisory in nature and may provide the Health Access Program with input on matters including: setting membership rates; designing the range of benefits and health care services for participants; and researching utilization, actuaries, and costs.

The Health Access Program shall offer the opportunity for employers to enroll their employees and for individual enrollment by July 1, 2007.

B. Employer Health Expenditures

The measure requires that employers engaging in business within San Francisco, that are required to obtain a valid San Francisco business registration certificate from the San Francisco Tax Collector's office, or an employing unit as defined in the California Labor and Unemployment Codes, with a minimum of twenty (20) covered employees, or in the case of a nonprofit corporation, fifty (50) or more covered employees, make health expenditures on behalf of employees. The expenditures shall be made on a quarterly basis and will be required after an employee has been paid for ninety (90) days. The measure also sets penalties and provides for enforcement by the City's Office of Labor Standards Enforcement (OLSE).

Under the measure, "Health Care Expenditure" means any amount paid by a covered employer to its covered employees or to another party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its employees, including, but not limited to:

(a) contributions by such employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect, without regard to

whether such contributions qualify for a tax deduction or are excludable from employee income,

(b) reimbursement by such employer to its covered employees for incurred health care expenses,

(c) payments by an employer to a third party for the purpose of providing health care services for covered employees,

(d) costs incurred by an employer in the direct delivery of health care services for covered employees, and

(e) payments by an employer to the City to fund health services for uninsured San Francisco residents, including employees.

Notwithstanding any other provision of this subsection, such term shall not include any payment made directly or indirectly for workers' compensation, the Civilian Health and Medical Program of the Uniformed Services, or Medicare benefits.

"Employer" shall mean an employing unit as defined in Section 135 of the California Unemployment Insurance Code, or a person as defined in Section 18 of the California Labor Code, including all members of a controlled group of corporations. A "controlled group of corporations" shall have the meaning given in Section 1563(a) of the Internal Revenue Code, except that "more than 50 percent" shall be substituted for "at least 80 percent" wherever such term appears in Section 1563(a)(1) of the Internal Revenue Code and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code.

The measure does not include within the definition of "Covered employees" those employees subject to the Health Care Accountability Ordinance, Chapter 12Q of the San Francisco Administrative Code.

For medium-sized businesses employing between 20 and 99 employees, the required expenditure would be 50 percent of the ten-county survey rate used to set health care contributions for City employees. For large business employers with 100 or more employees, the required expenditure rate would be 75 percent of the ten-county survey rate.

The required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours for which its covered employees were paid during the quarter (including only hours starting on the first day of the calendar month following ninety (90) calendar days after a covered employee's date of hire) by the applicable health care expenditure rate. In determining whether a covered employer has made its required health care expenditures, payments to or on behalf of a covered employee shall not be considered if they exceed the number of hours for which the employee was paid during the quarter multiplied by the applicable health care expenditure rate.

Proposed amendments include: revising the effective date for participation in the Health Access Program from January 1, 2007 to July 1, 2007; the City Controller shall maintain any required health care expenditures made by an employer to the City separate from the general

funds; and the City shall maintain an education and advice program to assist employers with meeting the requirements of the measure.

Additional reporting obligations are proposed in the amended measure: the Controller shall report to the Board of Supervisors on a quarterly basis on the implementation and effect of the Health Access Program and the Health Expenditure requirements. The City Controller shall also report within sixty (60) days after any significant event affecting the implementation of the measure, in which case the Board of Supervisors shall hold a hearing within thirty (30) days of receiving the report to consider responsive action. The Department of Public Health and the OLSE shall report to the Board of Supervisors by January 31, 2007, on the development of rules for the Health Access Program and for the enforcement and administration of the employer obligations under this Chapter. The Board of Supervisors shall hold a hearing on the proposed rules to ensure that participants in the Health Access Program shall have access to high quality and culturally competent services.

The measure shall become operative in three phases. The day this Chapter becomes effective, implementation of the Chapter shall commence. The Health Access Program and any requirements placed on medium-sized or large businesses with fifty (50) or more covered employees shall become operative on July 1, 2007. Any requirements placed on medium-sized businesses with twenty (20) or more covered employees shall become operative on January 1, 2008. This Chapter is intended to have prospective effect only.

Background Information

All San Francisco residents should have quality, affordable health care. Currently, approximately 82,000 adult San Francisco residents are uninsured, even though more than half of those individuals are employed. San Francisco taxpayers bear the cost of paying for emergency room visits and other unnecessarily expensive health care for the uninsured. By establishing a Health Access Program for uninsured San Francisco residents with an emphasis on preventive care, and by requiring businesses to make reasonable health care expenditures on behalf of their employees depending on the businesses' ability to pay, the burden on San Francisco taxpayers for providing health care for the uninsured can be reduced. At the same time, San Francisco can offer uninsured individuals the choice to enroll in a system that provides quality health care for an affordable price and offer employers the choice to enroll their employees in that system. San Francisco also has a vital interest in preventing a "race to the bottom" in which employers stop paying for employee health care to remain competitive and instead shift those costs to San Francisco taxpayers.

Item 4 – File 05-1919

Note: The proposed Amendment of the Whole (see Description section below) was continued at the July 5, 2006, meeting of the Budget and Finance Committee.

Department:

Department of Administrative Services –
Office of Labor Standards Enforcement (OLSE)
Department of Public Health (DPH)
Office of the Controller –
Office of Economic Analysis

Item:

Ordinance amending the San Francisco Administrative Code by adding Sections 14.1 through 14.8, to provide health care to San Francisco residents by (a) creating a public health access program for uninsured San Francisco residents, (b) requiring that employers doing business in San Francisco, employing at least 20 employees, make health care expenditures on behalf of their employees; (c) identifying options for how an employer may make such expenditures; (d) creating an advisory health access working group; and, (e) setting an operative date.

Description:

The proposed ordinance is an Amendment of the Whole merging two proposed ordinances, File 05-1919 and File 06-0893, into one File 05-1919. The Budget Analyst's report below is unchanged with respect to the original report on File 05-1919, the "Worker Health Care Security Ordinance," and has added one Comment with respect to

the original report on File 06-0893, the "San Francisco Health Access Program."

Description of the Original File 05-1919: The proposed ordinance would require that employers operating within San Francisco who employ at least 20 employees, or nonprofit agencies who employ at least 50 employees, to make health care expenditures on behalf of their employees for the purpose of either (a) providing health care coverage to such employees or (b) reimbursing the cost of health care for such employees. The proposed ordinance would authorize "health care expenditures" to include expenditures by covered employers for their employees for (a) health savings accounts, (b) reimbursement of health care costs incurred by covered employees, (c) payments to a third party for the purpose of providing health care services, (d) costs incurred by an employer in the direct delivery of health care services to covered employees, and (e) payments by an employer to the City to fund health services for uninsured San Francisco residents.

Required Health Care Expenditures by Employers

The proposed ordinance would require all "covered employers"[1] to make health care expenditures for "covered employees"[2] at a rate equal to (a) 75 percent for covered employers employing 100 or more covered employees, and (b) 50 percent for covered employers employing between 20 and 99 covered employees and covered nonprofit agencies employing between 50 and 99 covered employees.[3] The rate to be paid to provide for employee

[1] The proposed ordinance defines a "covered employer" as "any medium or large business [as defined within the proposed ordinance] operating within the City that is required to obtain a valid San Francisco business license from the San Francisco Tax Collector's Office, or, in the case of a nonprofit corporation, a business with a minimum of fifty (50) covered employees."

[2] The proposed ordinance defines "covered employee" to mean anyone who has performed at least two hours of work per week over a period of ninety days for a covered employer, provided, however, that a covered employee "shall not include persons who are managerial, supervisorial, or confidential employees, unless such employees earn annually under $72,450 or in 2007 and for subsequent years, the figure as set" by the OLSE. The proposed ordinance further states that "covered employees" will not include employees covered under the City's Health Care Accountability Ordinance.

[3] The proposed ordinance further authorizes that any businesses that are part of a larger corporation which has a controlled share of 50 percent or more of such businesses will be considered as one employer for the purposes of this ordinance. For example, if a corporation has three franchises with 50 covered employees each and has a controlled share of more than 50 percent for each of the three franchises, then all three franchises would be considered as one employer with 150 employees. Therefore, each of the three franchises would be required to provide health care expenditures at a

health care services shall be at the average contribution rate approved by the Board of Supervisors based on the City's Health Service System annual ten-county survey amount for the applicable fiscal year and paid by the City through its Health Service System, which in FY 2006-2007 is $365.66 per month, or approximately $4,388 annually.

The Budget Analyst calculates that under the proposed ordinance, the health care expenditure rate to be paid by covered employers for each full-time covered employee would be (a) $274.25 per month (75 percent of $365.66) per full-time covered employee, or approximately $3,291 annually, for covered employers employing 100 or more covered employees; and (b) $182.83 per month (50 percent of $365.66) per full-time covered employee, or approximately $2,194 annually, for covered employers employing between 20 and 99 covered employees and covered nonprofit agencies employing between 50 and 99 covered employees.

The proposed ordinance would prorate the health care expenditure rate on an hourly basis, dividing the monthly average expenditure rate by 172 hours per covered employee and multiplying by the actual number of hours worked by all covered employees. For example, if a covered employee of a covered employer worked 86 hours in one month, the monthly health care expenditure rate to be paid by the covered employer would be one-half of the full-time covered employee amount above, or $137.13 (50 percent of $274.25) if the covered employer employs 100 or more covered employees.

The proposed ordinance would further prohibit an employer from (a) reducing the number of covered employees or (b) reducing the number of employees who perform compensated work for such employers, for the purpose of evading the obligations of this proposed ordinance. Under the proposed ordinance, the employer will be responsible to demonstrate that any reduction in

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rate of 75 percent (and not 50 percent, as would be the case for up to 99 employees) of the average contribution rate approved by the Board of Supervisors based on the City's Health Service System's annual ten-county survey.

the number of covered employees was not done in order to evade the obligations of the proposed ordinance.

Covered employers would be responsible for (a) maintaining accurate records of health care expenditures and proof of such expenditures made each quarter, and (b) providing an annual report to the Department of Administrative Services Office of Labor Standards Enforcement (OLSE) containing information, as required by OLSE, regarding the employers' compliance with the proposed ordinance.

Projected Enforcement Costs to the OLSE

The OLSE would be responsible for enforcement of the proposed ordinance, including (a) review of the annual reports and annual records of health care expenditures submitted by all covered employers subject to the provisions of the proposed ordinance; (b) notification to the employer of violation of the provisions of the proposed ordinance, the required corrective action, and amount of penalties that may be imposed (the penalty amount may be up to one and one-half times the total expenditures that the employer failed to make); (c) handling of appeals by employers who OLSE has determined to be in violation of the proposed ordinance; and, (d) investigation of complaints submitted by covered employees whose employers do not provide health care benefits or funding for health care expenditures.

The Attachment is a memorandum from Ms. Donna Levitt of the OLSE which states that OLSE estimates the total costs for enforcement of the proposed ordinance, including staffing and mailing costs, would be $450,000 annually. Additionally, Ms. Levitt estimates one-time costs incurred by OLSE for enforcement of the proposed ordinance at $30,000. According to Ms. Levitt, such funds to cover the enforcement costs will be included in a future budget request by OLSE. Ms. Levitt advises that total enforcement costs may change over time as OLSE is better able to determine appropriate staffing and supply costs. The Budget Analyst will review any future budget request, including funding sources, which is submitted to the Board of Supervisors.

Description of the Original File 06-0893: The proposed ordinance would direct the Department of Public Health (DPH) to create and oversee a San Francisco Health Access Program (HAP) which would provide medical services to uninsured San Francisco residents for the prevention, diagnosis, and treatment of medical conditions, excluding vision, dental, cosmetic, and outpatient mental health services.

As stated in Section 19.4 of the proposed ordinance, the proposed HAP would be a "partnership between the Department of Public Health and various private and public entities. It may be funded from a variety of sources, including payments from employers and individuals, and the City and County of San Francisco. City funding shall prioritize Program services for low and moderate income participants, and will subsidize where possible, participation by businesses with fewer than one hundred (100) employees." The Budget Analyst notes, however, that the proposed ordinance (a) does not specify any mechanisms for implementation and administration of the proposed HAP and (b) does not specify any funding sources for the proposed HAP (see Comment No. 1).

Dr. Mitch Katz, Director of DPH, advises that total estimated costs of the proposed HAP would be approximately $198,030,000 annually, which DPH calculates using an estimate[4] of $201.25 cost per HAP member per month, or $2,415 annually, and including an estimated 82,000 uninsured San Francisco residents who would be members in the proposed HAP.

Of this estimated $198,030,000 total annual program cost for 82,000 members, Dr. Katz advises that DPH estimates potential funding sources would total an estimated $200,000,000 to $229,000,000 annually. The potential funding sources shown in the table below were provided by Dr. Katz.

[4] Dr. Katz advises that such estimate was prepared for DPH by an actuary, Milliman Inc., which was paid by Kaiser Permanente to calculate such estimate.

Potential Funding Source	Estimated Annual Amount
City's Contribution	$104,000,000
Employers' Contributions	30,000,000 – 49,000,000
Individual Enrollment Copay Contributions	56,256,000
Federal and State Programs	10,000,000 – 20,000,000
Total	**$200,256,000 - $229,256,000**

With respect to the City's contribution amount of $104,000,000 above, Dr. Katz advises that DPH has based this estimate on total costs which DPH expended in FY 2004-2005 to provide medical services to uninsured San Francisco residents. All such City costs will be subject to appropriation approval by the Board of Supervisors.

With respect to the employers' contributions estimate of $30,000,000 to $49,000,000 above, the Budget Analyst notes that this range of estimated funds is based on a report prepared by the Controller's Office of Economic Analysis on the original File 05-1919, which would require covered San Francisco employers to make health care contributions on behalf of their covered employees. The Budget Analyst notes that, while covered San Francisco employers would be required to make health care contributions on behalf of their covered employees, such employer contributions would not necessarily accrue to the proposed HAP. The Budget Analyst further notes that the estimated amount of $30,000,000 to $49,000,000 is the Controller's total estimate of employer health care contributions which would be realized under Section 14.1(b)(5) of the proposed Amendment of the Whole. Such health care contributions could include:

(a) Contributions by such employer on behalf of its covered employees to a health savings account;
(b) Reimbursement by such employer to its covered employees for expenses incurred in the purchase of health care services;
(c) Payments by an employer to a third party for the purpose of providing health care services for covered employees;
(d) Costs incurred by an employer in the direct delivery of health care services for covered employees; and,

(e) Payments be an employer to the City to fund health services for uninsured San Francisco residents (the proposed HAP program, File 06-0893).

The Budget Analyst notes that, based on the Controller's Office of Economic Analysis estimates, the proposed HAP includes an identified funding source in the Employers' Health Care Contributions estimate of $30,000,000 to $49,000,000 which could be expended by employers on any one or combination of five different options and not necessarily accrue to the proposed HAP. Therefore, under the proposed HAP, employers could contribute nothing to HAP.

With respect to the Individual Copay Contributions estimate of $56,256,000 above, the basis for such estimate is shown in the table below, provided by Dr. Katz.

Income Level of Uninsured San Francisco Residents*	Individual Enrollment Copay	Estimated Size of Population	Estimated Annual Revenue
Less than 200%	$3 per month	31,000	$1,116,000
Between 200% and 500%	$35 per month	17,000	7,140,000
Greater than 500%	$200 per month	20,000	48,000,000
	Total	**68,000****	**$56,256,000**

*Income level is defined as a percentage amount of the Federal Poverty Line.

**Dr. Katz advises that the estimated size of the population of 68,000 paying the Individual Enrollment Copay is 14,000 less than the estimated 82,000 uninsured San Francisco residents who could receive services under the proposed HAP because DPH estimates approximately 14,000 uninsured residents would have their health care expenditures paid by their employers under the proposed ordinance and therefore would not pay an Individual Enrollment Copay.

The Budget Analyst notes that, in its calculation of $104,000,000 in City Contributions by DPH for uninsured patients in FY 2004-2005, DPH further estimated total collections from uninsured patients to be $2,151,000, which is $54,105,000, or 96.2 percent less than the above estimated Individual Enrollment Copay annual revenues of $56,256,000. Under the proposed HAP, patients would be required to pay Individual Enrollment Copay contributions in the amounts specified above, determined based on the individual's income as a percentage of the

Federal Poverty Line (FPL).[5] Further, Dr. Katz advises that DPH anticipates that individuals with incomes which are greater than 300 percent of the FPL will be the last to be enrolled in the proposed San Francisco Health Access Program (HAP).

With respect to the Federal and State estimated funding source of $10,000,000 to $20,000,000 for the proposed HAP, Dr. Katz advises that the availability of such funds will depend on (a) the level of experience of service providers and their ability and capacity to leverage Medi-Cal funds and (b) future modifications in State and Federal law which may reduce or increase the total amount of such funds available to DPH to fund the proposed HAP. Dr. Katz advises that DPH collected $22,325,603 in such monies in Calendar Year 2004 to provide medical services to uninsured San Francisco residents.

Comments:

1. At the July 5, 2006 meeting of the Budget and Finance Committee, the proposed ordinance was amended by the Committee to require DPH and OLSE to report to the Board of Supervisors by January 31, 2007, on the development of specific rules to be formulated for the proposed HAP and for the enforcement and administration of employer obligations under the proposed ordinance.

2. The Budget Analyst notes that the proposed ordinance funding source of $56,256,000 in annual Individual Enrollment Copay contributions is $54,105,000, or 96.2 percent more than the total estimated collections of $2,151,000 from uninsured patients utilizing San Francisco City health facilities in FY 2004-2005. Further, as shown in the table on the previous page, $48,000,000, or 85.3 percent of the Individual Enrollment Copay contributions, would be collected from 20,000 patients each contributing $200 per month. Dr. Katz advises that, should these patients not participate in the proposed HAP, DPH would not incur costs for such patients and, therefore, DPH would not need the Individual Enrollment Copay contribution revenues from such patients.

[5] In FY 2005-2006, the Federal Poverty Line for an individual was annual income of $9,800.

Memo to Budget and Finance Committee
July 11, 2006 Special Budget and Finance Committee Meeting

Recommendation: Approval of the proposed ordinance is a policy matter for the Board of Supervisors.

Harvey M. Rose

cc: Supervisor Daly
Supervisor Dufty
President Peskin
Supervisor Elsbernd
Supervisor Mirkarimi
Supervisor Alioto-Pier
Supervisor Ammiano
Supervisor Ma
Supervisor Maxwell
Supervisor McGoldrick
Supervisor Sandoval
Clerk of the Board
Controller
Noelle Simmons
Cheryl Adams

MEMORANDUM

Date: January 27, 2006
To: Luke Klipp, Office of the Budget Analyst
From: Donna Levitt
Re: Enforcement of the Worker Health Care Security Ordinance

The proposed Worker Health Care Security Ordinance designates the Office of Labor Standards Enforcement (OLSE) as the administering agency.

Functions to be performed by OLSE include :

- develop a procedure and mechanism for the filing of annual reports
- review compliance with the annual reporting requirement
- review annual reports for compliance with required health care expenditures
- investigate claims of non-compliance / audit employers' records, as appropriate
- issue notices of violation with corrective action needed and any penalties that may be assessed
- monitor compliance with corrective action needed
- defend OLSE findings through the appeal hearing process
- support the Task Force on the health security fee
- OLSE may promulgate rules necessary for implementation of the ordinance

Based on information from the Tax Collector's Office, OLSE assumes that approximately 4000 businesses in San Francisco employ 20 or more people and are covered by the ordinance.

Based on available information, OLSE proposes the following staffing and annual budget to enforce the ordinance :

1 FTE 2978 Contract Compliance Officer II	130,000
2 FTE 2992 Contract Compliance Officer I	200,000
1 FTE 1446 Secretary II	70,000
Annual mailing to registered businesses	50,000
TOTAL	**450,000**
Computers / phones / office space (one time expense)	30,000

File # 051919

Office of Economic Analysis

Economic Impact Report
Of the Proposed
Worker Health Care Security Ordinance
File No. 051919

File Description:

Ordinance amending the San Francisco Administrative Code by adding Sections 14.1 to 14.10, to require that certain employers operating within San Francisco make health care expenditures on behalf of employees, identifying options for how an employer may make such expenditures, setting penalties and providing for enforcement, and setting an operative date.

Proposed Ordinance Summary:

- Impacts for-profit employers operating in San Francisco with more than 19 employees.
- Impacts non-profit employers operating in San Francisco with 50 or more employees.
- Covered employees include any person, regardless of residence, who works in San Francisco for a covered employer, full time or part time, for at least 2 hours per week, for at least 90 days, under the Minimum Wage Ordinance (Proposition L, 2003; see section 12R of the City's Administrative Code for further details).
- Qualifying health care expenditures include amounts paid by a covered employer to a covered employee or to a third party on behalf of its covered employees for the purpose of providing health care services or reimbursements for such services—excluding payments to State or Federal Government for Worker's Compensation or Medicare benefits.
- Mandates minimum health care expenditures as calculated by the formula:
    - For For-Profit Businesses with over 19 employees but less than 100 employees: 50% times the City's Annual 10-County Health Survey Rate (a monthly rate) divided by 172 hours times the number of covered employee hours worked per month.
    - For For-Profit Business with 100 or more employees: 75% times the City's Annual 10-County Health Survey Rate (a monthly rate) divided by 172 hours times the number of covered employee hours worked per month.
    - For Non-Profit Businesses with 50 but less than 100 employees the 50% rate as discussed above, and for Non-Profit Businesses with 100 or more employees the 75% rate as also discussed above.

June 23, 2006

Executive Summary

While the majority of San Franciscans benefit from health insurance coverage, an estimated 82,000 to 148,000 go uninsured for at least some period of time during the year. Lack of insurance coverage impacts both residents as well as some non-residents who commute into San Francisco for work. The problem of the uninsured is large both nationally and at the state level, where an estimated one in five Californians are uninsured. This legislation proposes to remedy at least a portion of the problem at the local level by mandating minimum health care expenditure requirements for San Francisco-based for-profit covered employers with more than 19 employees working in the city and for San Francisco-based non-profit covered employers with 50 or more employees working in the city.

Our economic impact analysis projects that an estimated 14,070 to 19,570 people could gain increased access to health care benefits at an estimated projected cost of $30.9 to $49.0 million in the first year of coverage. We project that these costs will be immediately felt by employers and predominantly by smaller employers with less than 50 employees, as they currently are less likely to offer health benefits to their employees. Over time, however, we project that employees will ultimately pay, at least part if not all of the cost of these new benefits through otherwise lower wage increases. Employers operating in a competitive marketplace have limited resource capacity to pay toward personnel compensation costs (including both wages and fringe benefits). In the short-run, we project that for some businesses the increased cost of doing business in San Francisco will be greater than is supportable through price increases or existing profit margins, resulting in estimated losses of between 60 and 590 full-time jobs. Conversely, 150 to 240 full-time healthcare jobs could be created if all of the costs represented increased consumption of health services within San Francisco, assuming no gains in efficiency in the delivery of healthcare. The combined range in the change in jobs is estimated to be at the most a net gain of 90 jobs to a potential loss of 350 jobs. This range is relatively minor, as compared to net job growth in the current economy. As a point of reference, the City experienced estimated growth of 3,000 to 5,000 net new jobs in 2005, and we project similar job growth in the coming year.

As with any analysis, certain assumptions and survey data were used. A few key limitations or constraints included:

- limited survey data for the San Francisco jurisdiction with regard to job by establishment size, so we used the establishment survey data from the California Economic Development Department even though that data did not disaggregate jobs by part-time, seasonal or full-time;
- limited ability to further project, at a business level, how some specific industries such as restaurants or temporary services agencies could be uniquely impacted;
- limited ability to quantify the potential positive spillover effects that society may experience as health benefit coverage rates increase -- often cited examples include a more productive, healthier workforce and savings to the public health safety net;
- uncertainty at an employee level as to how health care expenditures will ultimately be allocated (e.g. through health savings accounts or insurance with potential co-payment requirements) and where that health care will occur (in San Francisco or outside of our jurisdiction); and
- uncertainty about what the ultimate composition of resident versus non-resident covered employees would be.

Given these limitations and unknowns, it seems most helpful to first summarize key risks, then evaluate the potential impact by stakeholder.

Risk Factor Schedule

Risks	Possible mitigating actions by local governments
Employers operate in a highly competitive environment and must continually adjust their hiring decisions based on market wage and benefit trends. To the degree businesses can pass through labor cost increases onto consumers in the form of higher prices for goods and services, they may be able to absorb this mandate. However, many businesses operate with limited profit margins, so some business closures are likely.	• Consideration of a lower mandated spending minimum, or a longer transition time, for smaller companies as well as companies that have significant number of temporary staff and less profitable industries may help mitigate the risk of smaller company closures and job losses in the short-term.
Having one jurisdiction with a mandate as compared to a region, state or nation, can put that jurisdiction at greater risk for jobs loss. Health benefit mandates increase the cost of doing business in San Francisco. This increases the risk that employers will leave or not locate in our jurisdiction if other jurisdictions lack those same mandates. This risk could grow as the cost of the mandate grows over time.	• Encourage a legal mandate at the State and Federal level for coverage minimums that require all employers to provide at least a base level of health benefits, such as this proposed mandate and/or support of broader mandates at the State level—for example, California SB. 840. • Structure the health care expenditure mandate to an index other than the City's 10-County Survey Rate. Other factors could be the Consumer Price Index (CPI) or a regional Labor Cost Index.
Proposed ordinance does not differentiate residency, benefiting both non-resident and resident uninsured employees at the expense of San Francisco based businesses and government. This could have the effect of San Francisco subsidizing neighboring jurisdictions' public health needs. That being said, it may also attract more employees to seek work in the City putting downward pressure on wages.	• Increasing health benefits for non-resident employees helps neighboring counties' public health safety nets at the expense of San Francisco employers. If funding were to instead accrue to the San Francisco public health safety net, a direct alignment between benefits and costs to San Francisco stakeholders would occur.
Since a number of smaller businesses disproportionately have more part-time staff, more firms may be impacted with increased costs (administrative and mandate) than the establishments survey data suggests.	• Consideration of a longer transition time, for smaller companies that have significant numbers of part-time staff may help mitigate these risks in the short-term.
The proposed legislation provides a great deal of potential local remedy for what is a complex national and statewide problem; however, at the same time a number of unknown variables exist.	• Given the magnitude of this undertaking and the significant number of unknowns involved, a gradual or phased approach may be warranted.

Stakeholder Description	Qualitative Net Benefit Ranking				
	Extreme adverse impact	Moderate adverse impact	Neutral	Moderate favorable impact	Extreme positive impact
City Economy					
Covered Employers NOT Currently Providing Health Care Benefits at Mandated Levels					
Covered Employers Already Paying Health Care Benefits Above the Mandated Levels					
Covered Employees with Health Care Benefits Less than Mandated Levels					
Covered Employees with Health Care Benefits Above Mandated Levels					
City and County Government					

Economic Effects	If this ordinance passes	Without ordinance
City Economy	Nearly Neutral Impact: • The estimated incremental cost of this ordinance on San Francisco employers ranges between $30.9 M and $49.0 M in the first year of implementation, which by economy-wide standards is small as most employers with more than 19 employees already provide coverage. • Projected 140 to 250 new health care jobs assuming service is provided in San Francisco. • Projected 60 to 590 jobs losses, predominantly from staff cuts or business closures at employers with 20 to 49 employees. Reductions will likely impact lower-wage employees disproportionately.	• The Bay Area Economic Forum, using data from the 2003 California Health Interview Survey (CHIS) estimated that, in 2003, 148,000 San Franciscans were uninsured, at some point over a year's time. • The San Francisco Mayor's Universal Healthcare Council, 2006, estimated that on average 82,000 persons were without coverage per year. • San Francisco's daytime population is significantly greater than our resident population due largely to non-resident workers commuting into the city each day. Some of these workers are uninsured. • Using Metropolitan Transportation Commission (MTC) commute pattern estimates, total uninsured resident (employed and unemployed) as well as non-resident (employed) persons may total as much as 189,000 over the course of the year.[1] • Employers have been shifting health benefit costs onto employees through increased deductibles, higher co-payments and co-insurance.
Covered Employers NOT Currently Providing Health Care Benefits at Mandated Levels	Moderate Adverse Impact: • Employers with more than 19 but less than 100 employees shall provide health care expenditures of no less than ~~$2,194 annually~~ per covered full-time employee[2] (Estimated to pay approximately $29.3 M to $31.0 M, in first year). • Employers with 100 or more employees shall provide health care expenditures of no less than $3,291 annually per covered full-time employee[3] (Estimated to pay approximately $1.6 M to $18.0 M in first year). • According to the California Health Care Foundation 2005 Survey, the average employer contribution toward employee health care in California is $3,361 annually – an amount that exceeds both proposed mandate levels currently. • Over time, mandated health care expenditure growth is likely to continue exceeding the average rate of inflation – historically the 10-County Rate has risen on average 7.4% to 8.1% per year over the past 10-20 years, compared to an average of 2.5% for overall inflation for the San Francisco Bay Area. • Increase in administrative costs as they must maintain health expense records and report annually to the Office of Labor Standards Enforcement (OLSE) to demonstrate compliance.	

[1] This count includes unemployed residents and employees not covered by the plan as they may be self-employed, or employed by businesses not covered by this ordinance's definition—i.e., companies with fewer than 20 employees.
[2] Calculation takes 50% of the 10-County Survey Rate x 172 hours per month x 12 months per year x # of full-time equivalent employees per year, in verifiable health care expenses on behalf of his/her employees.
3 Calculation takes 75% of the 10-County Survey Rate x 172 hours per month x 12 months per year x # of full-time equivalent employees per year, in verifiable health care expenses on behalf of his/her employees.

Economic Effects	If this ordinance passes
Covered Employers ALREADY Providing Health Care Benefits Above Mandated Levels	Neutral Impact initially to Moderately Adverse over time. • No short-term significant impact when employers are spending $2,194 annually per employee, for firms with more than 19 but less than 100 employees, or $3,291 annually per employee, for firms with 100 or more employees. • Will see some increase in administrative costs as they must maintain health expense records and report annually to the Office of Labor Standards Enforcement (OLSE) to demonstrate compliance. • Potential adverse impact to employers over time if the rate of growth in the City's Annual 10-County Health Survey limits the flexibility that employers have in shifting health costs onto employees through required higher deductibles, co-insurance and co-payments.
Covered Employees with Health Care Benefits Less than Mandated Levels	Moderate Favorable Impact: • Projected to benefit an estimated 14,070 to 19,570 covered employees currently uninsured and employed in San Francisco, regardless of residency. • Incremental benefit per employee (and cost to employer) represents 15.9% to 3.5% of overall total wage costs for firms not currently providing health care benefits, assuming an average wage range of $10.00 to $30.00 per hour for qualified employees[4]. • Depending on the average wage of impacted businesses, we project an estimated loss of 60 to 590 full-time jobs.
Covered Employees with Health Care Benefits Above Mandated Levels	Neutral to Moderately Favorable Over Time: • Employees expected to continue to benefit, though employers will now have a minimum expenditure level that they must provide. This may provide some protection from increased cost shifting, but will also likely otherwise decrease wage growth over time.
City & County Government	Neutral to Moderate Favorable Impact: • Reportedly, the ordinance may cost at least $0.48 million in additional costs at the City, primarily at the Office of Labor Standards Enforcement plus some potentially minor amount of additional operating costs to Controller's Office for appeals adjudication.[5] • Payroll Tax revenues may be impacted depending on the change in jobs. • Non-profit contracting costs may also be impacted depending on amount of City funding provided to non-profits to cover incremental costs. • Projected numbers of covered employees who benefit are 14,070 to 19,570 compared to the projected job losses of 60 to 590 (mainly smaller employers) with potential offsetting new health care jobs of 150 to 240. • Increased coverage may relieve some of the burden on the health safety net provided by the Public Health Department; however, our assumption is that these potential savings would be reprogrammed to provide further unmet public health needs.

[4] This range of salary covers hourly wages for most employees who earn at or below the wage median, per recent (Second Quarter, 2005) California Employment Development Department Quarterly Employment and Wages Survey

[5] See also the Budget Analyst Fiscal Impact Report on file 05-1919 dated June 1, 2006. Submitted on June 7, 2006.

SUMMARY OF COSTS AND BENEFITS

City Economy

Our office estimates a relatively neutral overall economic impact to the city economy from the implementation of this ordinance as currently drafted. The estimated cost to be paid by covered employers is projected to be between $30.9 million to $49.0 million. Additionally, an estimated $0.48 million is projected for City costs, primarily related to the Office of Labor Standards Enforcement (OLSE).

In the short-term businesses will shoulder the cost of this ordinance. Most of the burden will fall onto businesses with 20 to 49 employees, as these firms currently are less likely to offer health care benefits to their employees. [6] Over time, though, employees will bear at least a portion if not all of these costs through lower wage increases, as fringe benefits become a larger proportion of their total compensation.

The ordinance will significantly increase the cost of labor for employers who employ lower-wage workers because fixed monthly health care expenses represent a larger proportion of total compensation costs for lower-wage employees.[7] For example, given an employer who hires fewer than 100 employees, with average employees earning $10.00 per hour, without health benefits, will become $10.00 per hour plus $1.06 per hour for health benefits – reflecting increased total compensation costs of 10.6 percent. This is three times the impact compared to a company with an average hourly wage rate of $30.00 (only a 3.5% effect).

Our estimates assume that this legislation does not generate a substitution (or "magnet") effect among qualified employers who currently pay for health care expenses that are greater than the proposed fee level per employee. *Substitution* or *magnet effects* describe the occurrence of employers substituting less expensive alternatives that still meet the threshold of this ordinance. Both, Cutler, et. al. (1995) and Shepard-Shore, et. al. (2000), show empirical evidence of employers opting to offer employees less expensive health benefit alternatives as less expensive alternatives become available or become the market norm. Although these two academic exercises deal with insurance per se, the Health Care Security Ordinance is <u>not</u> an insurance mandate — rather it is a health benefits spending mandate.

Another assumption we made is that currently, employers offering health benefits are generally spending at least as much as this ordinance mandates, which for FY 2006-07 is either $2,194 or $3,291 annually depending on the size of the employer. While this appears to be consistent with the 2005 Employer Health Benefits Survey, conducted annually by the Kaiser Family Foundation, over time employers have increasingly shifted costs onto employees thereby limiting the employer share of benefit cost increases. These data are averages, so it is possible that some firms pay less than the mandated levels while others pay more and possibly provide both employee and dependent coverage. To the degree the 10-County Survey Rate rises faster than overall total compensation growth, employers would have less flexibility to further shift health benefits costs onto employees.

The City's Annual 10-County Health Survey Rate has been rising faster than general inflation, as have health insurance premiums generally over the last two decades. Figure 1 shows the effect of this growth rate over time.

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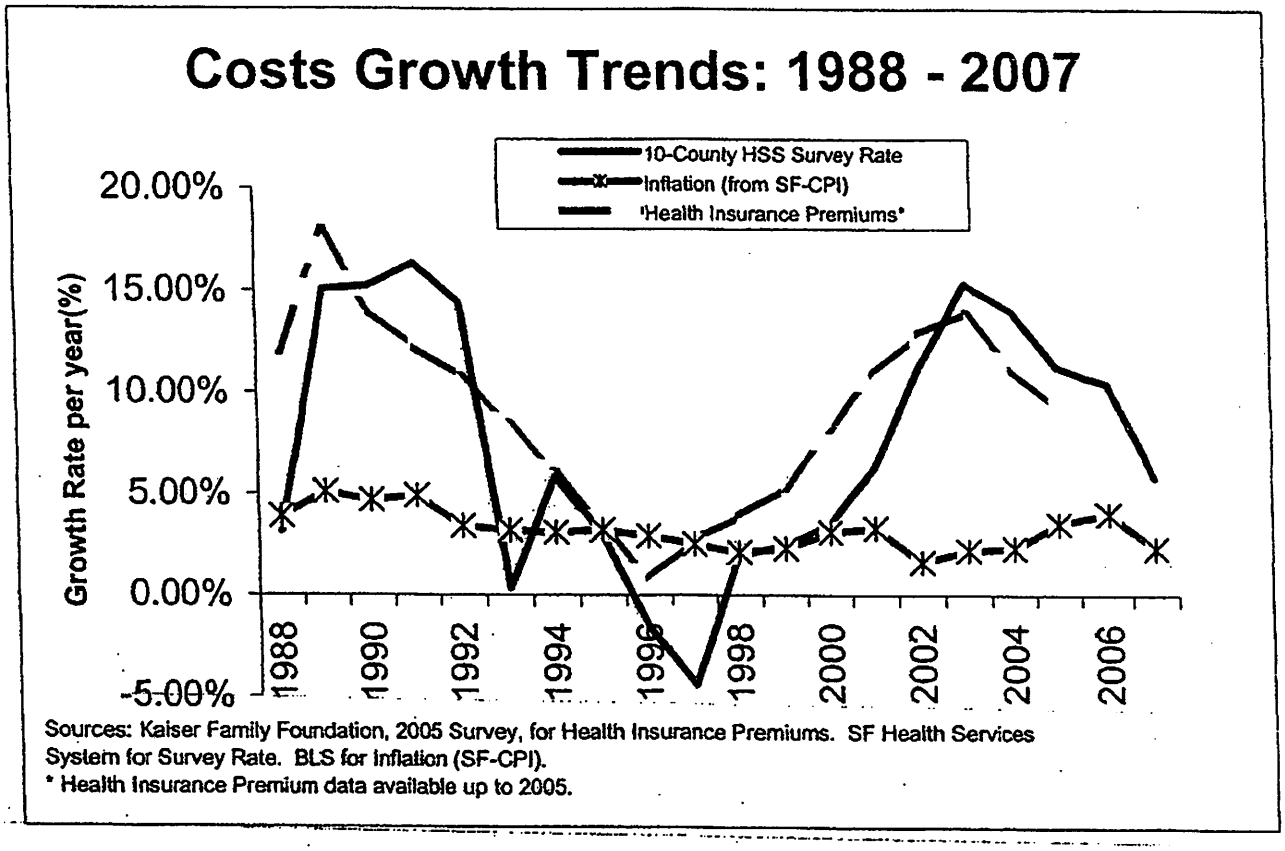
[6] For example, locally owned and typically owner operated restaurants, business services and retail establishments.
[7] The 2005 CHCF Survey finds that only 35% of low-wage paying firms, and 33% of businesses with many part-time employees offer health care expense coverage.

Figure 1



Employers Covered Under this Proposed Ordinance

Table 1 on the follow page illustrates Health Care Benefits by Business Size in San Francisco. Consistent with studies of Bay Area Employer Provided Healthcare[6], most workers who are projected to be positively impacted by this legislation work in smaller businesses — businesses between 20 to 49 employees.

[6] See referenced studies in the bibliography by the Bay Area Economic Forum, and by UC Berkeley with Working Partnerships USA.

Table 1. Health Care Benefits by Business Size

Impact of Ordinance		Number of Businesses by Size						
		Total	20-49	50-99	100-249	250-499	500-999	1000 or more
Total Businesses[1]		42,864	2,594	890	494	144	58	34
Covered Employers		4,214	2,594	890	494	144	58	34
Jobs		530,452	89,493	66,305	86,203	53,928	43,471	63,654
% of Employers Offering Health Coverage	UC Berkeley Study[2]		87%	95%	97%	97%	99%	99%
	California Health Care Foundation Survey, 2005[3]		88%	95%	98%	98%	98%	98%
	Kaiser Family Foundation National Survey, 2005[4]		74%	87%	92%	92%	99%	99%
Businesses Impacted	UC Berkeley Study	402	337	45	15	4	1	0
	California Health Care Foundation Survey 2005	371	311	45	10	3	1	1
Jobs Impacted	UC Berkeley Study	*14,070*	11795	1575	525	140	35	0
	California Health Care Foundation Survey 2005	*19,572*	10,730	3,353	1,745	1,124	750	1,872
Employer Costs in Millions	UC Berkeley Study	$ 30.87	$ 25.88	$ 3.46	$ 1.15	$ 0.31	$ 0.08	$ 0.00
	(%)	100.0%	83.8%	11.2%	3.7%	1.0%	0.2%	0.0%
% Burden of Cost	California Health Care Foundation Survey 2005	$ 48.96	$ 23.54	$ 7.36	$ 5.74	$ 3.70	$ 2.47	$ 6.16
	(%)	100.0%	48.1%	15.0%	11.7%	7.6%	5.0%	12.6%

1. Data Source: California EDD, Second Quarter 2005 Estimate.
2. UCBLC Study, Refers to UC Berkeley Labor Center and Working Partnerships USA Study, Declining Job-Based Health Coverage in the United States and California: A Crisis fro Working Families, by Arindrajit Dube and Ken Jacobs.
3. Source of estimated %: Bay Area Economic Forum Study, January 2006, and California Health Care Foundation Survey, 2005. State based survey.
4. Source of estimated %: Kaiser Family Foundation Survey, 2005. National Based Survey.

We expect 48.1 to 83.8 percent of the total estimated $30.9 to $49.0 million in health benefit mandated costs will fall on businesses employing between 20 to 49 employees. Businesses of 20 to 49 employees are projected to be most affected by the provisions of this ordinance because they are less likely to provide health benefits currently as well they are more likely to employ lower wage employees.

Table 2 below illustrates how firms with lower-wage dmployees will be disproportionately impacted because this new mandate will represent a significant cost over and above the current wage base in the short-term. For example, a firm with an average wage of $10 per hour will see their personnel costs increase by 10.6 to 15.9 percent with the implementation of this ordinance.

Table 2. Firms with Lower Average Wages Impacted More

			100 or more employees (75% of 10-County Rate)		>19 to <100 employees (50% of 10-County Rate)	
		Average Wage	Minimum Health Care Expense Required[1]	% Of Wage	Minimum Health Care Expense Required[2]	% Of Wage
Scenario A	Hourly	$ 10	$ 1.59		$ 1.06	
	Monthly	$ 1,720	$ 274.25	15.9%	$ 182.83	10.6%
	Annual	$ 20,640	$ 3,290.94		$ 2,193.96	
Scenario B	Hourly	$ 20	$ 1.59		$ 1.06	
	Monthly	$ 3,440	$ 274.25	8.0%	$ 182.83	5.3%
	Annual	$ 41,280	$ 3,290.94		$ 2,193.96	
Scenario C	Hourly	$ 30	$ 1.59		$ 1.06	
	Monthly	$ 5,160	$ 274.25	5.3%	$ 182.83	3.5%
	Annual	$ 61,920	$ 3,290.94		$ 2,193.96	
CCSF 10-County Survey Rate for FY 2006-07						*$ 365.66*
Implied Hourly Rate ("the Rate") for Health Care expense per employee per hour						$ 2.13
Implied Annual Health Care Expenditure / employee						$4,387.92
1. Expense required is 75% if "the" Rate, for businesses with >100 employees						
2. Expense required is 50% if "the" Rate, for businesses with >19 & <100 employees						

These cost increases may be absorbed by some employers or passed onto customers through higher prices. However, other employers will find these alternatives less possible and will choose to cut jobs or hours worked or possibly close their businesses altogether. To estimate the impact of job losses, we have summarized in Table 3 on the following page the projected reduction in total hours worked. For example, a business that has an average hourly wage of $10 and employs more than 19 but less than 100 employees would likely cut total labor hours by between -1.06 to -3.19 percent to offset the additional costs associated with increased health benefits. This estimate assumes that businesses are unable to cover these additional costs through achieving other expenditure efficiencies, otherwise lowering profits or through higher prices to customers. This reduction in the demand for labor can be translated into job losses by taking the # of affected jobs (estimated to be between 14,070 and 19,572) times the labor reduction factor of -1.06 to -3.19 percent – yielding estimated losses of 150 to 620 jobs.

The significance is really that the proposed ordinance more significantly impacts smaller employers, since they hire a greater proportion of the lower-wage workers in the Citx. Also, because of the competitive nature of the marketplace, our projections assume that costs of providing higher benefits cannot entirely be passed through to the customers by increasing prices, nor that a firm's owner will be able to cover increased costs by reducing profits.

Table 3. Changes to Jobs: % Reduction Yielding 60 to 590 Job Losses

			100 or more employees		>19 to <100 employees	
			Low elasticity of demand for labor -0.1	High elasticity of demand for labor -0.3	Low elasticity of demand for labor -0.1	High elasticity of demand for labor -0.3
		Wage	Estimated % Reduction in Demand for Labor			
Scenario A	Hourly	$ 10	-1.59%	-4.78%	-1.06%	-3.19%
	Monthly	$ 1,720				
	Annual	$ 20,640				
Scenario B	Hourly	$ 20	-0.80%	-2.39%	-0.53%	-1.59%
	Monthly	$ 3,440				
	Annual	$ 41,280				
Scenario C	Hourly	$ 30	-0.53%	-1.59%	-0.35%	-1.06%
	Monthly	$ 5,160				
	Annual	$ 61,920				

Table 4 shows the distribution of Hourly, Monthly, and Annual minimum health care expense coverage total costs that firms of different sizes (measured by number of full time equivalent employees) will face under this proposed ordinance.

Table 4. Schedule of Minimum Health Care Expenses Paid by Covered Employers Under the Health Care Security Ordinance

Covered Employers' Establishment Size	Minimum Required Total Health Care Expense		
	Hourly	Monthly	Annual
20	*$ 21.26*	*$ 3,657*	*$ 43,879*
30	*$ 31.89*	*$ 5,485*	*$ 65,819*
40	*$ 42.52*	*$ 7,313*	*$ 87,758*
50	*$ 53.15*	*$ 9,142*	*$ 109,698*
60	$ 63.78	$ 10,970	$ 131,638
70	$ 74.41	$ 12,798	$ 153,577
80	$ 85.04	$ 14,626	$ 175,517
90	$ 95.67	$ 16,455	$ 197,456
100	$ 159.44	$ 27,425	$ 329,094
150	$ 239.17	$ 41,137	$ 493,641
200	$ 318.89	$ 54,849	$ 658,188
250	$ 398.61	$ 68,561	$ 822,735
500	$ 797.22	$ 137,123	$ 1,645,470
1000	$ 1,594.45	$ 274,245	$ 3,290,940

Likely Range of Greatest Adverse Impact to Business

Table 4 illustrates projected costs for the first year of ordinance implementation. For example, for businesses with 20 to 50 employees, projected first year costs of $43,879 to $109,698 are anticipated. While some employers are meeting or even exceeding these levels currently, a key concern will also be the potential rate of growth of the 10-County Survey and resulting mandated cost increases over time. This would mean that the ordinance's impact is also likely to grow over time.

Employees Covered Under this Proposed Ordinance

Employees who currently do not receive health benefits will benefit greatly from this ordinance in the immediate future. An estimated 14,070 to 19,570 employees will be positively impacted. The proposed ordinance results in additional health benefit expenses on behalf of employees that amount to 3.5 to 15.9 percent increases in total compensation, depending on the average wage of the firm. Based upon our review of labor economic research, increased wage costs result in reductions to labor of 0.1 to 0.3 percent for each 1.0 percent increase in total compensation costs. Thus, the positive impacts on employees by this ordinance will be partially offset by estimated job losses of 60 to 570.[9] While job losses are projected to occur primarily among smaller employers, as they disproportionately do not currently provide health benefits, some job gains are also expected in the health care industry. Depending on the rate of incremental health care spending that occurs within San Francisco, job gains in health care could range from 150 to 240.

City & County Government

The Budget Analyst's Report dated June 19, 2006, outlines a projected fiscal impact of $0.48 million due to higher administrative costs associated with oversight of company health care expense reporting. In addition to these costs, the City's payroll taxes could be impacted depending on the number of general job losses versus health care job gains. The City may also be indirectly impacted to the degree that non-profits that contract with the City see increasing health benefit mandated costs. In some cases, these increased costs may be passed through to the City's General Fund.

The City, as the public health safety net provider, is also projected to benefit as more people have access to health care. Since the cost of the uninsured falls largely on taxpayers as well as the insured through higher premiums, the City should see at least some reduction in the rate of safety net spending growth. When businesses fail to cover their employees, taxpayers ultimately bear the burden of providing care. This also means that businesses that do not offer insurance have a cost advantage over competitors that do, effectively adding to the burden of taxpayers. This ordinance helps to eliminate the implicit subsidy being afforded to firms that do not offer benefits as well as levels the playing field to their peers that already provide coverage.

This proposed ordinance would also have some effect on increasing the demand for public health care services in San Francisco by both City residents and covered employees residing in neighboring counties. That being said, depending on how much incremental spending the projected $30.9 to $49.0 million represents, some need for expansion of health care resources—capital and jobs— to ensure access may occur.

This legislation also creates spillover benefits for neighboring jurisdictions whose residents are employed in San Francisco if working in San Francisco means that they are more likely to have health benefits and less likely to be a burden on their jurisdiction of residence public health system. While the costs to San Francisco businesses should provide benefits to their employees, it will at the same time provide an implicit subsidy to a worker's place of residence whether that is in or outside of San Francisco County.

[9] The demand elasticity of labor is a number that measures how sensitive employers are to a change in the cost of hiring. We can use this concept to estimate the impact of a reduction in the cost of labor on employment. For example, if the demand elasticity of labor were –1, a 1% decrease in payroll costs would increase employment by 1%. Economic studies such as the ones in the bibliography and quoted in the next footnote suggest the demand elasticity of labor is between –0.1 and –0.3.

Conclusion

If implemented, this ordinance will have benefits and costs both of which could grow significantly over time. While overall the ordinance appears to be economically beneficial, some employers will be adversely impacted (and may even close) and some people that work for firms that cannot afford coverage will lose their jobs.

Our economic impact analysis projects that an estimated 14,070 to 19,570 people could gain increased access to health care benefits at an estimated projected cost of $30.9 to $49.0 million in the first year of coverage. These costs will be immediately felt by employers and predominantly by smaller employers with less than 50 employees, as they currently are less likely to offer health benefits to their employees. Over time, however, we project that employees will ultimately pay a portion if not all of the cost of these new benefits through otherwise lower wage increases, as employers operating in a competitive marketplace have only so much resource capacity to pay toward personnel compensation costs (including both wages and fringe benefits). In the short-run, we project that for some businesses the increased cost of doing business in San Francisco will be greater than is supportable through price increases or existing profit margins, resulting in estimated losses of between 60 and 590 jobs. On the other hand, between 150 to 240 healthcare jobs could be created if all costs represent increased consumption of health services within San Francisco.

Appendix A: Summary of SB 840 (Kuehl) - California Health Insurance Reliability Act

Governance: A Health Insurance Commissioner, elected every eight years with a two-term limit, will supervise the California Health Insurance Agency, which administers the California Health Insurance System. The Commissioner appoints the Deputy Health Insurance Commissioner, the Health Insurance Fund Director, the Consumer Advocate, the Chief Medical Officer, the Director of Health Planning, the Director of the Partnerships for Health, the Director of the Payments Board, and the Regional Health Planning Directors.

Health Insurance Policy Board: Chaired by the commissioner, includes the seven appointed state officers, the state public health officer and two representatives from Regional Planning Boards. A Public Advisory Committee to advise the board, representing doctors, nurses, hospitals, dentists, health practitioners, pharmacists, mental health providers, consumers, businesses, and labor will be appointed by the Assembly, the Senate, and the Governor.

The Health Insurance Policy Board:

- Establishes scope of services.
- Sets priorities and guidelines for evaluations, research, capital investment, and public input.
- Determines need for change or increase in health insurance premiums.

Office of Consumer Advocate: Responds to and facilitates consumer complaints and suggestions. Establishes Independent Medical Review System to provide examinations of disputed health care services. Collaborates in forming Partnerships for Health.

Office of Health Planning: Plans for the health needs of the population, establishes system performance criteria, identifies health outcome disparities and service shortages and recommends corrective steps, establishes statewide health care databases to support planning and performance review, plans for system capital investments, and links state and private research to health system goals.

Office of Health Care Quality: Headed by the chief medical officer, sets standards of best medical practice, recommends an evidence-based formulary for pharmaceuticals and durable equipment, identifies treatments and medications that are safe and effective, recommends means to achieve an appropriate ratio of general practitioners to specialists. Collaborates in forming Partnerships for Health.

Health Insurance Fund: Receives and disburses all monies to be expended on health care.

Payments Board: Composed of finance and insurance experts and representatives of commissioner and regional directors. Plans compensation for upper level private health care managers, and health care providers. Three-year compensation plans made after negotiations with health care facilities and representatives of provider groups.

Providers may choose fee-for-service compensation or salaries within health care systems. Facilities, integrated health care systems and group medical practices can choose capitated or non-capitated operating budgets. Payments may include bonuses for meeting the goals of the system. Employee unions will negotiate with the regional director.

Inspector General of the California Health Care System: Establishes an inspector general, in the office of the Attorney General, and appointed by the Governor, with authority to investigate fraud or misconduct by employees of the Health Care Agency, or by providers or consumers.

Health Care Regions: Up to 10 regions are established by the commissioner, headed by Regional Health Planning Directors, with funding established by the commissioner, to support local decision making in the health planning process. Patients may receive care in more than one region. Each region has a Partnership for Health.

Partnerships for Health: Establishes in the California Health Insurance Agency and in each region by collaboration between the consumer advocate, the chief medical officer, and the regional advocates and directors. Each Partnership for Health supports health maintenance, disease prevention, good communication between patients and providers, health education and better quality of care.

Transition: A transition Commissioner of Health Insurance, appointed by the Governor with Senate confirmation, will serve until the first election. With help from a transition advisory group, the transition commissioner will initiate the system, attempt to recover certain moneys to help fund the system, oversee the transition from contracted private insurers to the public system, and assist persons displaced from employment by the new system with retraining and job placement.

Eligibility: All state residents are covered, including undocumented residents, Californians traveling out of state for up to 90 days, and California retirees living out of state if they pay required taxes to the Health Care Fund. No waiting period for at least two years. Visitors will be charged prevailing rates.

Benefits: Inpatient and outpatient services by health facilities, physicians, or licensed health care professionals, diagnostic imaging, laboratory services, durable medical equipment including prosthetics, eyeglasses, and hearing aids, rehabilitative care, emergency or necessary transportation, language interpretation, immunizations, preventive care, health education, hospice care, home health care, prescription drugs, mental health care, dentistry, podiatry, chiropractics, acupuncture, religious healing that is protected under federal or state statutes, blood products, emergency care, vision care, adult day care, case management, substance abuse treatment, dialysis, and up to 100 days in a skilled nursing facility. If the budget permits, the Commissioner may add benefits above these required by the bill.

Excluded: Cosmetic procedures and private hospital rooms with no medical indication, care by unlicensed providers, and procedures or medications with no proven medical value. Chief Medical Officer may authorize treatment not included in the benefit package.

Budget: Prepared annually by the Commissioner. Includes facility and provider budgets for both fee-for-service and integrated systems (capitated or non-capitated budgets), capital investment, purchasing, research and innovation, and workforce development.

Capital expenditures: Capital improvements to health care facilities will be in accordance with plans made by the commissioner and regional directors. All capital investments including facility improvements, land and office space purchases and large medical equipment purchases are subject to the capital planning guidelines. The commissioner will establish standards for small capital expenditures funded through operating budgets. Capital improvements shall minimize unneeded expansion of facilities and services, and correct health care disparities. The system will not pay for mandatory earthquake retrofits.

Research: Includes studies to improve quality of health care, administration of the system, communication among health care providers, and education of patients.

Cost containment: The commissioner and regional directors are responsible for keeping the overall costs within the budget. The bill mandates that spending will grow no faster than the average growth in state GDP and population growth. Statewide or regional cost containment methods will or may include:

- Streamlining administration, with costs limited to a specified, low percentage of system budget.
- Developing electronic billing and reporting systems.
- Postponing new benefits or new capital investment, or a temporary decrease in benefits.
- Adjusting provider reimbursements to correct for inappropriate utilization.
- Limiting provider reimbursements above a specified amount of aggregate billing.
- Deferred funding of the Reserve Account.
- Negotiating bulk purchasing of pharmaceuticals and medical equipment.
- Limiting aggregate reimbursements to pharmaceutical manufacturers.
- Avoiding regional duplication of expensive services.
- Imposing a waiting period for new residents, if a large number of people are entering the state for the purpose of obtaining health care.
- Establishing consumer co-payments and/or deductibles, if necessary, only after the first two years, and limited to $250 per person or $500 per family. The commissioner shall establish standards for waiver of co-payments for those with low income.

When cost control measures are insufficient: Commissioner may ask the Legislature for an increase in health care taxes.

Funding: All federal, state and county monies currently spent on health care will be reallocated to the state Health Care Fund. This will supply about one-third of the needed funding. Federal waivers are required for allocation of federal dollars to the state Health Care Fund. The remaining funding will come from state health taxes that will replace health insurance premiums now paid to insurance companies and co-pays and deductibles now paid to providers. Premiums will be affordable for every Californian and every business because what families pay is in proportion to their income and what employers pay is in proportion to wages. Single-payer efficiencies control costs. Most businesses and families will save money.

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