FINAL REPORT TO MAYOR GAVIN NEWSOM

SAN FRANCISCO HEALTH ACCESS PROGRAM: SERVING UNINSURED ADULTS

UNIVERSAL HEALTHCARE COUNCIL

June 23, 2006

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Executive Summary

An estimated 82,000 adult residents in the City and County of San Francisco lack health insurance. In many respects, the demographics of San Francisco's adult uninsured population is similar to what is found nationally -- a relatively young (59% are under the age of 40), majority male (59%), employed (56%), low-income (45% earn under $20,000 a year) population.

These residents have limited access to routine preventative care, suffer from poorer health outcomes, delay seeking treatment when ill and ultimately rely on more costly episodic or emergency care for health conditions that could be treated in primary care settings. The lack of health insurance negatively impacts individuals both in terms of health status and financially. It also takes a toll on the health care delivery system, taxpayers and society.

Continuing to serve uninsured residents in an episodic, fragmented delivery system is inefficient, costly and counter to the larger goal of improving health status. Adequately providing services to San Francisco residents must be viewed within a larger policy and programmatic framework that examines the financing and delivery of health services across all providers in the public and non-profit sectors.

The City and County of San Francisco has long had an interest in ensuring that all uninsured San Francisco residents have access to health services. In 1998, San Francisco voters approved a Declaration of Policy urging the City and County to expand health care coverage. Since that time, the City and County has expanded health care coverage to children, In Home Supportive Service workers and certain young, low-income parents. It also adopted an ordinance that expanded coverage for employees of City and County contractors. More recently, Mayor Newsom created and seated the Universal Healthcare Council (UHC) to further the goal of expanding access to health services.

The UHC was charged with developing the parameters of a program that would provide healthcare to the 82,000 uninsured San Francisco residents. The UHC was designed as a collaborative effort with representatives from health care, business, labor, advocacy organizations, philanthropy, research and other disciplines. Central to the context of a collaborative effort is the notion of collective responsibility. The UHC strongly believes that expanding access to the uninsured requires participation from all interested parties – individuals, employers, public and private health care providers, and the government.

Based on its vision statement and principles, the UHC recommends development and implementation of the *San Francisco Health Access Program (SF HAP).* SF HAP is an innovative public/private partnership of community providers serving the uninsured population. It will provide prevention, primary care, specialty, pharmacy, laboratory, radiology and inpatient services. SF HAP provides an affordable alternative to health insurance – it emphasizes prevention, provides a package of services, promotes choice of providers, recognizes the importance of affordability, and maintains a focus on accountability (in terms of both health outcomes and fiscal oversight). As designed, it takes advantage of a locally developed, not-for-profit, State licensed health plan.

In addition, the development of SF HAP will enable providers and delivery systems to pilot, refine and implement innovative models of care for serving uninsured residents. The UHC views SF HAP as a catalyst to changing the current system of care for uninsured residents. The UHC recognizes that San Francisco's public and non-profit providers cannot continue to deliver services in the same manner to uninsured residents because the current systems of care do not allow providers to optimally meet patient needs. There is a need to propose and try new modalities and approaches to the delivery of services. SF HAP:

- links uninsured residents to a primary care providers,
- facilitates an individual receiving care in a timely manner,

- provides a payment mechanism for services that uninsured residents might otherwise not receive and
- invests in innovations in the delivery of care.

It is important to realize that no program, even a joint public/private partnership such as the San Francisco Health Access Program will provide everything that a person might want to everyone who might demand or expect it. This is not a realistic expectation. Therefore, is must be stressed that SF HAP will not solve the uninsured crisis nor will it remedy underlying problems in the financing of health care. It will however, enable San Francisco to improve the delivery of care for uninsured residents who are now faced with a complex, uncoordinated 'system' of care.

It is estimated that the *San Francisco Health Access Program* will cost approximately $200 million a year (in 2006 dollars) or roughly $2,400 a year for each uninsured resident. SF HAP would be financed by a combination of employer, individual, the City and County of San Francisco contributions, and other public sources. SF HAP would be administered by the San Francisco Health Plan. Individuals would enroll and select a provider from the Health Plan's network. Due to the inherent complexities involved in developing and implementing a new program, the UHC recommends that SF HAP be implemented on an incremental basis.

While the UHC undertook its work, it was aware of an ordinance that had been introduced at the San Francisco Board of Supervisors regarding health care for San Francisco workers. The Worker Health Care Security Ordinance, introduced by Supervisor Ammiano, would require certain San Francisco employers to contribute a minimum health care expenditure on behalf of their employees. The UHC did not consider the merits of this legislative proposal, but sought to create a program that would be consistent with and complement the legislation if it were passed. As such, the Council's report does not specifically address aspects of this pending legislation.

Similarly, while the UHC unanimously agreed that the business community should contribute financially to meeting the health needs of the uninsured, it did not, and was not charged with determining how best to achieve this financial participation. It was recommended by the UHC that any fiscal policy on this issue first be tested or modeled with actual San Francisco businesses to determine the impact on businesses' financial viability. The UHC notes that during its deliberations, several businesses offered to open their financial records for this type of analysis.

I. INTRODUCTION

An estimated 82,000 adult residents in the City and County of San Francisco lack health insurance. In February 2006, Mayor Gavin Newsom created and seated the Universal Healthcare Council (UHC). The UHC's charge was to develop the parameters of a program that would provide health care for all uninsured San Francisco residents. The UHC is a collaborative effort with representatives from health care, business, labor, advocacy organizations, philanthropy, research and other disciplines. Attachment A provides a list of UHC members.

In order to develop the parameters of a program that would expand access to care for uninsured residents, the UHC set out to:

- adopt a vision statement and set of guiding principles,
- develop a common understanding of uninsured adults with respect to demographics, employment status and service utilization,
- propose a mechanism to expand health access to uninsured residents including financing structure,
- estimate the costs of expanded access to uninsured residents and
- identify the various implementation issues related to expanded access to uninsured residents.

II. A VISION: COMPREHENSIVE HEALTH CARE SERVICES FOR ALL

UHC's primary objective was to recommend a mechanism to expand health care access to uninsured San Francisco residents. In order to achieve this, the UHC first reached consensus on the overall vision for health care access in San Francisco. Fundamental to UHC's vision and goal is the notion of collective responsibility – all sectors of society must take a role in addressing the number of uninsured residents and in helping ensure access to care.

Vision Statement

All San Franciscans have timely access to comprehensive health care services.

The vision was carefully crafted to focus on the critical issue for uninsured persons – the lack of health care services. It is important to note that the vision does not specify the mechanism by which this would be achieved; in particular, it does not indicate expansion of health insurance. While the UHC recognizes that health insurance is the most likely approach to expanding health access, it is not the only model that can be used to accomplish this goal. In addition, due to federal law governing employer-based health insurance, the need to leverage existing State and federal funding serving the uninsured, and a strong desire to avoid the substitution of privately-funded health insurance with publicly-funded health services, the UHC deliberately did not opt to create a new health insurance program as a mechanism to expand access to uninsured adults.

UHC's goal is as follows:

Goal

San Francisco residents will have access to comprehensive health services and a 'medical home.' Such a program should "enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable."

The UHC seeks to ensure the following features:

- affordability for all financial contributors (i.e., tax payers, participants, employers, and the City and County),
- care delivery which emphasizes health promotion, prevention and primary care, and
- consistent, sustainable patient/provider relationship.

The UHC endorsed specific strategies that could be used to meet the vision, outlined a set of principles that would guide the development of this effort and identified key assumptions. The principles reflect the Council's desire to ensure a comprehensive set of benefits, an affordable package, a cost-effective administrative structure and an adequate provider network.

Given funding limitations, tradeoffs are inherent in any effort to expand access to an uninsured population. The UHC sought to identify these tradeoffs and develop principles that could take these into account. Attachment B provides the vision, goal, strategies, principles and assumptions endorsed by the UHC.

The UHC believes that in the absence of a statewide or national health insurance program that it is critical to preserve existing employer-based health care coverage. As a result, it did not envision any program developed under its auspices as competing with, creating an alternative to or undermining the maintenance and/or expansion of employer-based health insurance.

III. SAN FRANCISCO'S UNINSURED ADULT POPULATION

An estimated 82,000 San Francisco adults between the ages of 18 and 64 are uninsured.[*] Uninsured residents lack appropriate access to primary, specialty and inpatient services. As a result, they delay seeking care, seek preventive services at lower rates, have poorer health status and outcomes and have less access to physician services. Whenever care is needed, uninsured residents must navigate a cumbersome and fragmented delivery system comprised of safety net and traditional providers within the public and non-profit sectors. The following tables[†] provide general demographic information on the estimated 82,000 adult uninsured residents.

Table 1
Distribution across Income Level

Poverty Level	Number	Percentage
0-99%	17,000	21%
100-199%	20,000	24%
200-299%	15,000	18%
300% +	30,000	37%

Source: 2003 California Health Interview Survey (CHIS)

Table 2
Distribution across Gender

Gender	Number	Percentage
Female	34,000	41%
Male	48,000	59%

Source: 2003 California Health Interview Survey (CHIS)

Table 3
Distribution across Age

Age	Number	Percentage
18-24	8,000	10%
25-39	40,000	49%
40-64	34,000	41%

Source: 2003 California Health Interview Survey (CHIS)

[*] 2003 California Health Interview Survey.
[†] 2003 California Health Interview Survey.

Table 4
Distribution across Employment Status

Age	Estimated Number	Percentage
Employed	46,000	56%
Unemployed	36,000	44%

Source: 2003 California Health Interview Survey (CHIS)

As the data indicates, 45% of the uninsured earn incomes at or below 200% of the Federal Poverty Level (equates to under $19,600 for one person), 59% are under the age of 40 and over 50% are employed. With respect to employment status, of those who are employed, 83% (38,000) work more than 20 hours per week and 17% (8,000) work less than 20 hours per work. The data starkly reveal that over half of San Francisco's uninsured adult population are employed, but lack health insurance principally because it is either not available from their employer or if available, not affordable to the employee.

It is important to recognize that few if any uninsured adults (employed or unemployed) qualify for publicly-funded health coverage. California's Medi-Cal program provides medical assistance to certain individuals and families with low incomes and resources. However, being low-income does not automatically qualify individuals for the program. Only persons meeting certain eligibility requirements qualify such as children, pregnant women, persons with disabilities, etc. A relatively healthy, low-to-moderate income, working, uninsured adult is not eligible for Medi-Cal.

As a result, when uninsured adults need health services, they access a variety of systems: community clinics, public clinics and hospitals, non-profit hospitals (via charity care), and private providers. Due to their uninsured status, they access services in an episodic manner. Some may receive only emergency services at a hospital while others may have a more longstanding provider at a community clinic. In addition, uninsured residents may use multiple providers to get the services they need. The service delivery and financing systems for the uninsured are an inefficient and under-resourced patchwork that leaves providers confused and patients with less than optimal care.

As part of its work, the UHC examined the number of uninsured who utilize the following safety net systems:

- San Francisco Department of Public Health,
- San Francisco Community Clinic Consortium,
- Hospital Charity Care and
- AB 75 Project (Services for the Uninsured).

Demographic, service utilization, cost and financing data were collected. Attachment C provides a summary of the various sliding scale policies used by San Francisco providers to determine what level of payment will be sought from low-income residents who receive services. This is the first compilation of these policies and reflects the fragmentation that an uninsured individual faces when utilizing charity care services.

The principal service providers for the uninsured are the San Francisco Department of Public Health (served 50,000 uninsured adults in 2004) and the San Francisco Community Clinic Consortium Partner Health Centers (served 46,000 uninsured adults in 2004). As noted above, uninsured residents may use multiple providers. This is why the two figures, when combined, exceed 82,000.

Based on unique data identifying uninsured clients in the San Francisco Department of Public Health and AB 75 Project systems, it appears that as many as 57,000 (69% of 82,000) uninsured adults received services from public and non-profit providers in calendar year 2004. In keeping with the nationwide health care utilization patterns, 76% of those seeking care received outpatient services, 20% received emergency services and 4% received inpatient services. This utilization information was factored into how the UHC approached the development of an expanded program to provide access to the uninsured. Specifically, the data documented the need to ensure that any potential program provided sufficient access to outpatient-based primary and preventative care services.

IV. PROPOSED SAN FRANCISCO HEALTH ACCESS PROGRAM

Based on its vision statement and principles, the UHC has designed a new San Francisco Health Access Program (SF HAP). SF HAP is an innovative medical care program designed to deliver appropriate care to uninsured San Francisco residents. It provides preventive care, primary care, specialty care, urgent and emergency care, laboratory, inpatient hospitalization, radiology and pharmaceuticals. Innovation is an integral component of SF HAP because public and non-profit providers cannot continue to provide services in the current manner – the current system does not adequately meet patient needs. Innovation will enable providers and delivery systems to continually improve efficiency, productivity and quality of care. SF HAP is an innovation framework that capitalizes on the relative strengthens and expertise of public and nonprofit providers. SF HAP:

- links uninsured residents to a primary care providers ("medical home"),
- facilitates an individual receiving care in a timely manner,
- provides a payment mechanism for services that uninsured residents might otherwise not receive and
- invests in innovations in the delivery of care.

In developing this program, the UHC examined health access expansion efforts in other communities. A summary of some of these efforts is contained in Attachment D.

The UHC recognizes that health insurance is only one mechanism to expanding access to health services. Health insurance is primarily a financial vehicle that is used to obtain access to medical care and for reimbursing providers who deliver care – it is a mechanism to achieve health access. SF HAP **is not** insurance because it:

- does not provide as comprehensive a set of services as one might receive with health insurance,
- will not provide for services rendered outside of San Francisco and
- will not cover services rendered by providers that are not in the provider network.

In addition, it should be noted that because SF HAP is supported, in part, by a public subsidy generated from San Francisco government, non-San Francisco residents would be ineligible for the public subsidy.

The UHC recognizes that SF HAP is not intended to compromise or otherwise detract from the City and County's ability to satisfy its statutory obligations under California Welfare and Institutions Code Section 17000 to provide care to indigent persons. SF HAP offers the potential to improve the City and County's capacity to care for indigent uninsured residents. Within the context of the City and County's Section 17000 obligation, it is important to note that indigent residents and uninsured residents are not synonymous. Specifically, while an indigent resident is very likely to be uninsured, all uninsured residents are not indigent and therefore under the statutory obligation of Section 17000.

Below are SF HAP's major components:

- *Eligibility*: All San Francisco residents are eligible for the program regardless of employment or immigration status. There are no exclusions for pre-existing conditions. San Franciscans enrolled in the program as a condition of their employment may continue as individuals if they lose or change their jobs. In order to join the SF HAP, an individual must:
    - prove that they have been uninsured prior to program enrollment,
    - live in San Francisco and
    - be willing to apply for State and federal health benefits to which s/he is eligible.

- *Participation Requirement*: An employer may participate in SF HAP via employer contributions to provide health access to his/her employees. An individual may also enroll on his/her own. Because of SF HAP's voluntary nature, success will depend upon attracting individuals and perhaps their employers who believe that access to comprehensive health services is valuable. Businesses, community-based organization, faith-based entities and health care providers will all need to assist in the outreach efforts to fully maximize enrollment of this target population.

- *Scope of Services*: Table 5 provides the included services:

Table 5
San Francisco Health Access Program Proposed Scope of Services

Hospital Inpatient	*Hospital Outpatient*	*Physician*	*Other*
Medical Surgical Psychiatric Alcohol & Drug Abuse Maternity Skilled Nursing Care	Emergency Room Surgery Radiology Pathology Pharmacy and Blood Cardiovascular PT/OT/ST Maternity Non-Delivery	Inpatient Surgery Maternity Deliveries Maternity Non-Deliveries Outpatient Surgery Anesthesia Inpatient Visits Office/Home Visits Urgent Care Visits Therapeutic Injections Allergy Tests & Injections Misc. Medical Immunizations Physical Exams Vision, Hearing & Speech Exams Emergency Room Visits Specialty Consults Physical Therapy Radiology Pathology Podiatrist Outpatient Psychiatric Outpatient Alcohol & Drug Abuse	Prescription Drugs Home Health Ambulance DME/Prosthetics

Out-of-area, out-of-network, vision, dental, long-term care, fertility and cosmetic procedures are not included in the scope of services.

- *Provider Network*: The network of providers delivering services under SF HAP include primary care providers (doctors, nurse practitioners, etc.), specialists, clinics and hospitals. The pool of providers will be derived from the San Francisco Health Plan provider network. The current providers within the San Francisco Health Plan include:
    - over 400 primary care providers from UCSF, Kaiser, Department of Public Health, San Francisco Community Clinics, and private doctors,
    - 1,500 specialists,
    - the majority of the hospitals in the City (the Health Plan is currently in negotiations with St. Francis and St. Mary's hospitals – the inclusion of which in the Health Plan provider network would result in all San Francisco hospitals being part of this provider system).

  Although as yet non-quantified, the UHC recognizes that all of the providers of the San Francisco Health Plan spend some money providing care for the uninsured. Thus, the UHC hopes and assumes that San Francisco Health Plan providers would be willing to continue serving these individuals via SF HAP which will provide a more organized and efficient model of health care delivery.

- *Financing*: The UHC recognizes that the City and County cannot and should not, by itself, sustain a financial effort to expand health access to uninsured adults. The SF HAP is, therefore, financed through

a combination of employer, individual, the City and County of San Francisco contributions, and other public sources. Because SF HAP provides health care rather than insurance for health care, it maximizes federal and state sources of reimbursement for eligible SF HAP members. Costs are also contained by emphasizing preventive care and chronic disease management.

The employer contribution may depend on the size of the company (in terms of the number of employees). Individual contributions may in be the form of premiums and/or co-payments when accessing health services. If premium payments are incorporated, the UHC recommends that it not discourage enrollment and that it be tiered to family income levels. The City and County spends an estimated $104 million a year on the care of uninsured persons (based on fiscal year 2004-05 data). Some portion, but not all of these funds may be made available to subsidize the cost of SF HAP. The UHC recommends that the City and County's money subsidize low-income individuals (working and non-working) who may participate in SF HAP. In addition, the UHC recommends that the City and County continue to leverage federal and state funding to provide services to this population.

- *Administration*: The program is administered by the San Francisco Health Plan. The San Francisco Health Plan is a City-sponsored health plan providing health insurance to more than 50,000 San Franciscans. It was created by the City and County of San Francisco with one purpose: to provide high quality medical care to the largest number of low-income San Francisco residents possible, while supporting San Francisco's public and community-minded doctors, clinics, and hospitals. As the SF HAP Administrator it will provide multi-lingual customer assistance to ensure that each participant has a membership card, a list of providers, benefits and point of service charges, and assists members to identify a primary care "home." The Health Plan will also provide quality management to assure the highest quality of services possible is provided.

V. ESTIMATED SAN FRANCISCO HEALTH ACCESS PROGRAM COSTS

Estimated costs are based primarily on an actuarial analysis, which projected service utilization for the adult uninsured population (82,000). The predicted costs were derived based on the demographic characteristics of the estimated 82,000 uninsured adults in San Francisco. In addition to demographic information, the analysis took into account: (1) a scope of benefits and (2) a two-tiered co-payment structure based on family income. The actuarial analysis provides a broad estimate of potential utilization and costs of SF HAP; it is by no means definitive.

Point of service charges (i.e., co-payments) will be implemented based on income. Table 6 below indicates that the estimated annual cost (in 2006 dollars) of services through SF HAP is $2,415 per person.

Table 6
Estimated 2006 Costs Per Member

Reimbursement Rate	Monthly Rate	Annual Rate
Mixed Medi-Cal /Medicare Rate	$201.25 per person	$ 2,415 per person

Given that there are an estimated 82,000 uninsured San Franciscans this translates to a total cost of approximately $200 million. The per member, per month cost assumes that the entire 82,000 are enrolled in SF HAP (i.e., no adverse selection). If there is adverse selection, the per person cost will increase, but the overall cost may decrease due to the fact that some individuals not participating. It is important to acknowledge that the most significant factor influencing costs was the use of Medicare and Medi-Cal based reimbursement rates. The estimated cost includes administration performed by the San Francisco Health Plan. It is important to stress that the costs are estimates and that actual costs will be influenced by such factors as:

- pent-up demand for services by those who previously had limited access to care and
- increases in health care costs.

VI. IMPLEMENTATION RECOMMENDATIONS

The UHC was not charged with the task of implementing any potential health access expansion model. It has, however, identified several implementation tasks that should be addressed if the City and County decides to implement the San Francisco Health Access Program (SF HAP). Early in UHC's deliberations, it assumed that the implementation of any program would have to be phased in incrementally. Phasing in enrollment into SF HAP is critical because:

- appropriate planning must be undertaken given complexity of tasks needed to implement the program,
- significant systems change cannot be accomplished in "one giant leap" and
- an incremental approach provides opportunity to make appropriate adjustments and modifications in the program.

UHC offers the following implementation recommendations:

Program/Operations

- create the necessary implementation infrastructure to ensure that SF HAP is operational in 2007
- create a detailed operations plan
- identify the phase-in populations
- hold focus groups with key stakeholders to determine whether the proposed SF HAP would be attractive to: (1) San Francisco employers who do not provide health insurance to their employees and (2) uninsured San Francisco residents
- have the San Francisco Health Plan develop and enter into contractual obligations with a provider network
- provide a mechanism for consumer feedback/complaint process with respect to the delivery of services received via SF HAP
- determine how the SF HAP will intersect with existing sliding scale programs used by safety net providers or whether such programs should be modified or eliminated

Finance and Funding

- have the San Francisco Health Plan develop a detailed one-time start-up budget with identified funding sources
- create a detailed financial plan for long-term sustainability
- ascertain long-term financing and distribution of financial risk
- assess the potential to leverage and secure additional funds

Outreach

- engage in targeted discussions with the business and labor communities to ascertain the impact of participation in SF HAP on local businesses and their employees,
- develop and implement an outreach strategy plan that will attract potential participants and employers

Finally, the UHC believes that it is important to build in utilization and cost strategies that result in below market medical inflation. Specifically, SF HAP should be developed and implemented in such a manner that it actively works to constrain medical inflation in the cost of program (such as an appropriate pharmacy formulary, etc.). This will enable the City and County to keep SF HAP affordable in the long-term with redesign, best practices, strict disease management protocols and other program efficiencies.

ATTACHMENT A -- UNIVERSAL HEALTHCARE COUNCIL MEMBERSHIP

Co-Chairs
Lloyd Dean, CEO, Catholic Health Care West   Sandra R. Hernández, MD, CEO SF Foundation
Members

- Mike Alexander, COO, Northern CA Kaiser Foundation Hospital
- Larry Baer, Executive Vice President, SF Giants*
- Martin Brotman, MD, California Pacific Medical Center and St. Lukes
- Scott Campbell, MD, MPH, Emergency Medicine, Kaiser San Francisco
- Sophia Chang, M.D., California Healthcare Foundation
- Annie Chung, Self Help for the Elderly
- Michael Drennan, M.D., Director of Primary Care, DPH
- Rev. Elizabeth Eckdale, St. Mark's Lutheran Church
- Steve Falk, President, S.F. Chamber of Commerce
- Jean Fraser, San Francisco Health Plan
- Gordon Fung, MD, MPH, President, SF Medical Society
- John Gressman, ED., San Francisco Community Clinic Consortium
- Mary Ruth Gross, Director, Homecare Division, United Healthcare Workers-West
- Kevin Grumbach, MD, Professor and Chair of Family Practice, UCSF/SFGH
- Ed Harrington, Controller, City and County of San Francisco
- Father John Hardin, St. Anthony's
- Crystal Hayling, Blue Shield of California Foundation
- Steve Heilig, Policy Director, SF Medical Society
- Ken Jacobs, UC Berkeley Center for Labor and Research
- Mitch Katz, MD, Director of Health, SF Department of Public Health
- Mark Lampert, Social Invester*
- Mark Laret, CEO, UCSF Medical Center
- Ian Lewis, Local 2, HERE
- Bruce Livingston, Senior Action Network
- Fred Naranjo, Scarborough Insurance Agency
- Nathan Nayman, Committee on Jobs
- Gene O'Connell, RN Administrator, San Francisco General Hospital
- Michael O'Connor, Small Business Commissioner
- Tim Paulson, Executive Director, Labor Council
- Giselle Quezada, Young Workers
- Gladys Sandlin, Executive Director, Mission Neighborhood Health Center
- Mark D. Smith, MD, MBA, CEO California Health Care Foundation
- Abbey Snay, Executive Director, Jewish Vocational Services
- Cora Tellez, Healthcare Manager*
- Laurie Thomas, Rose Pistola and Rose's Cafe
- Ed Warshauer, Health Care Industry Staff Manager, SEIU Local 790
- Kevin Westlye, Golden Gate Restaurant Association
- Lucien Wulsin, Insure the Uninsured Project
- Jim Wunderman, Bay Area Council

* Designates that individual was appointed to the UHC, but was unable to participate in the deliberations.

ATTACHMENT B
VISION, GOAL, STRATEGIES, PRINCIPLES AND ASSUMPTIONS

Vision Statement
All San Franciscans have timely access to comprehensive health care services.

Goal
San Francisco residents will have access to comprehensive health services and a 'medical home.' Such a program should "enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable."

The UHC seeks to ensure the following features:

- affordability for all financial contributors (i.e., tax payers, participants, employers, and the City and County),
- care delivery which emphasizes health promotion, prevention and primary care, and
- consistent, sustainable patient/provider relationship.

Strategies

- Develop an affordable health access program for all uninsured San Franciscans, including low income workers who are unable to secure employer-based coverage and who are ineligible for publicly-funded health care programs such as Medi-Cal and Healthy Families.
- Develop a seamless, coordinated health program that provides access to comprehensive health care. This will include clarifying the eligible population and the scope and cost of benefits offered.
- Adopt guiding principles to inform the development of the program and to evaluate potential health access systems.
- Ensure that program participation by payers and participants is simple and efficient.
- Maintain and expand the political will to broaden policy support for expanding health care coverage to all uninsured San Francisco residents.
- Maximize eligibility by the uninsured and their families (i.e., dependents) to access publicly-subsidized health insurance programs for which they may be eligible, but not enrolled.
- Maximize all available state and federal reimbursement to fund services for target population(s).

Principles

- Access – Access to appropriate care is critical to improving health status.
- Accountability – The program will be accountable to program participants, the City and County, funders and the general public. The program will be accountable for fiscal and quality measures by tracking, documenting and reporting its progress and achievements on a regular basis.
- Affordability – Health access provided to the uninsured population will be affordable both in terms of the total monthly contributions and co-payments. The program should be affordable for individuals, employers, employees and the City and County.

- Choice – Program enrollees will have a limited choice of providers, clinics and facilities.

- Community Input – Expanding access to care necessitates building consensus among diverse stakeholders and seeking community input to develop and implement any local program.

- Cost-effectiveness – The program will make a commitment to using cost-effective services to promote affordability and sustainability.

- Crowd Out – The program will be designed to avoid potential "crowd-out" of employer-based coverage.

- Emphasis on Preventive and Primary Care – Health care services are better provided at the primary care level.

- Financial Contributions
  - Individual – Affordable premiums and co-payments will be instituted to create incentives for appropriate service utilization. The premiums will be designed based on the principle of affordability to encourage program participation by very low-income and minimum wage workers.
  - Employers – Employers who are currently not offering health benefits will contribute a specified amount towards the cost of providing the health care access program.
  - City and County – City and County funds will be used to help subsidize a portion of the program costs. Subsidization is only available for City and County residents.
  - Federal and State – The program will ensure continued access to federal and state funding that supports access to care for uninsured individuals.

- Financial Sustainability – Any health access program will be designed so that it is financially sustainable to ensure continued access to the target populations.

- Immigration status – Eligibility for the health access program will comply with San Francisco Administrative Code Chapter 12H whereby no department, agency, commission, officer or employee of the City and County of San Francisco shall use any City funds or resources to assist in the enforcement of federal immigration law or to gather or disseminate information regarding the immigration status of individuals in the City and County of San Francisco unless such assistance is required by federal or state statute, regulation or court decision.

- Leverage State and Federal Funding – Any health access program must avail itself of multiple funding sources and should strive to enhance access to state and federal funding that could be used to support the program's long-term sustainability.

- Outreach – Program participants will have timely and relevant information on how the program works, what is available to them and the benefits of the program in order to make a informed utilization decisions and in choosing from available providers.

- Program Coordination and Oversight – There will be programmatic coordination and oversight to determine best practices within the clinic setting and the hospital clinic relationship in order to assure the most medically effective, culturally sensitive and cost efficient services.

- Provider Participation – The program will promote and encourage the participation of healthcare providers in the San Francisco community in order to provide a network that ensures sufficient provider capacity and some choice of provider.

- Quality – Program participants will have access to health services that improve health outcomes, ensure appropriate utilization of services, focus on ensuring high quality care, and are effective, efficient and patient-centered.

- Residency – Eligible participants must reside in the City and County of San Francisco. Single Entry System – Create a seamless system for determining eligibility for the program to facilitate participant enrollment and to reduce both administrative costs and start-up time.

Assumptions
The health access program will be phased in over time so as to minimize overloading the current health care delivery system. Over time the program would be expanded to include as many of the uninsured as is possible. There will be analysis and monitoring of program to assess for unintended consequences (e.g., job loss due to burden of program on a business or business sector).

Employer and Employee Participation
- San Francisco-based employers with at least 20 employees will be targeted to participate in the health care access program. Other employers would be encouraged to voluntarily participate in the program.

- Given employer participation, the program must be designed and implemented such that all San Francisco employees of these employers participate in an effort to avoid adverse selection.

- If there is an employer mandate that applies to San Francisco, this program shall be consistent and coordinated with the mandated participation.

Delivery System
- The method of providing expanded access to the population is based on ensuring that participants have a regular primary care provider or site (i.e., a medical home).

- The health access program will emphasize the delivery of preventive and primary care services.

- San Francisco's health care safety net (both public and community-based) will be the primary vehicle used to expand access to care. This existing system will be expanded, where necessary to ensure that it has sufficient provider and facility capacity to accommodate the anticipated increased demand for services. The safety net system will work closely with the private, non-profit delivery system to ensure sufficient capacity and to assure access to necessary specialty care.

Financing
- The health access program will be financed by contributions from, uninsured individuals participating in the program, the City and County and employers.

ATTACHMENT C
SUMMARY OF SLIDING SCALE POLICIES

Hospitals

Hospital	Sliding Scale Eligibility
SFGH (and COPCs)	➢ Up to 100% FPL = Free ➢ 100-500% FPL = Sliding Scale (vary by inpatient, outpatient and dental)
Kaiser	➢ Up to 200% FPL = Free ➢ 200-400% FPL = Subsidized care (TBD)
CPMC and Saint Luke's	➢ Up to 400% FPL = Free
Saint Mary's and Saint Francis	➢ Up to 200% FPL = Free ➢ 200-300% FPL = Medicare rates ➢ 300-500% FPL = Managed care rates not to exceed 50% higher than Medicare
UCSF	➢ Up to 300% FPL = Free ➢ Above 300% FPL = 30% discount
Chinese	➢ Up to 200% FPL = Free ➢ Above 200% FPL = Up to 30% discount (case by case)

San Francisco Community Clinic Consortium Partner Health Center/Clinic Billing Policies

- ➢SFCCC partner health centers/clinics provide access to services without regard for ability to pay.
- ➢SFCCC "free clinic" partners do not charge for services (St. Anthony Free Medical Clinic, Haight Ashbury Free Medical Clinic, San Francisco Free Clinic).
- ➢Other SFCCC partners provide sliding-fee-scale discounts based upon a patient's income and family size in relation to federal poverty level guidelines.
- ➢Billing of uninsured patients, collection of co-payments or minimum fees, and screening for financial status are done in a culturally appropriate manner, to assure that they do not present a barrier to care.

Clinic	Sliding Scale Eligibility
Native American Health Center	➢ Up to 100% FPL = Free ➢ At 150% FPL = Pay 75% of charges ➢ At 200% FPL = Pay 95% of charges
South of Market Health Center	➢ Up to 100% FPL = Free ➢ At 150% FPL = Pay 60% of charges ➢ At 200% FPL = Pay 100% of charges
Mission Neighborhood Health Center	➢ Up to 100% FPL = Free ➢ At 150% FPL = Pay 65% of charges ➢ At 200% FPL = Pay 100% of charges
Curry Senior Center	➢ Not reported
Glide Health Services	➢ Not reported
Lyon-Martin Women's Health Services	➢ Not reported
North East Medical Services	➢ Not reported

ATTACHMENT D
SUMMARY OF HEALTH ACCESS EXPANSION EFFORTS IN OTHER COMMUNITIES

Model 1: Wellness Education Linkage Low-Cost (WELL) – San Mateo County, California

In 1996, San Mateo County initiated the WELL Program in order to improve the delivery of health care to low-income uninsured residents seeking care through the public health system. For eligible participants the WELL Program replaced the sliding scale as the method for tracking eligibility for services and obtaining payment from uninsured adults in San Mateo County. There are approximately 13,000 individuals enrolled in WELL. The creation of WELL was motivated by several factors, including:

- The high cost of screening people at each encounter and pursuing sliding scale payments;
- Multiple sliding scale payment categories were unnecessary since most individuals were very low-income and were eligible for similar sliding scale rates;
- The lack of clarity around available services for the uninsured deterred residents from seeking needed care.

The WELL Program includes the following components:

Sliding Scale	0-200% FPL = WELL 200 - 400% FPL = Billed at discounted price 400% + = Self pay (discount if portion paid w/in 30 days)
Eligibility	Up to 200% FPL Not eligible for other public insurance Mandatory for medically indigent adults
Enrollment Strategy	At point of service One-e-App electronic enrollment
Participant Costs	Up to 100% FPL: All fees and co-pays waived 100-200% FPL: $250 annual fee, co-pays
Provider Network	San Mateo Medical Center and 6 satellite clinics, 1 private community clinic (Ravenswood)
Administration	County Department of Public Health
Benefits	Inpatient, outpatient (includes PCP), specialty, emergency, rehabilitation, outpatient prescription, dental, case mgmt

As a result of WELL, San Mateo County has seen the following impacts:

- Administrative and collection costs were reduced by 26% in the first two years;
- Patient payments increased by 44% in the first two years.

Model 2: Wishard Health Advantage – Marion County, Indiana

Created in 1997, Health Advantage is a health cost assistance program, not an insurance program. It now has approximately 52,000 members receiving services at more than 20 provider sites. The program is available to uninsured individuals up to 200% FPL who are not eligible for other public insurance programs. Participants receive a comprehensive set of benefits at the public hospital and at public and private safety-net clinics. The program articulated the goal of shifting utilization away from episodic, hospital-based care toward primary and preventive care, and has utilized the following components to meet that goal:

- The primary care provider network includes public clinics and private safety-net providers (20+ provider sites);
- Members select a primary care site;
- Providers receive capitated payments for primary care;
- Specialty and emergency services are provided through the public hospital and clinics.

To date, Health Advantage reports the following impacts:

- Annual inpatient days for members have been reduced half;
- Emergency room utilization for members has decreased by about one-third.

Wishard Health Advantage includes the following components:

Sliding Scale	Yes
Eligibility	Up to 200% FPL Do not qualify for other public programs
Enrollment Strategy	Enrollment through 20+ providers Ind-e-App electronic enrollment
Participant Costs	No premium No co-pay up to 150% FPL Sliding scale co-pays from 150-200% FPL
Provider Network	Public hospital and clinics Private safety-net clinics
Administration	Health and Hospital Corporation of Marion County
Benefits	Routine exams, immunizations, gynecological care, specialty care, lab and x-ray services, prescribed medicines and emergency services

Model 3: Basic Health Care – Contra Costa County, California

Contra Costa created the Basic Adult Care program when the Medically Indigent Adult program was transferred to counties in 1982. Just recently, Contra Costa added coverage for children, following in the footsteps of the Healthy Kids programs in other counties. The program currently has 5,100 enrolled members.

While eligibility for the program is determined by the Health Services Department, management of the program is handled by the Contra Costa Health Plan (a division of the Health Department). All enrollees receive the same services as other Health Plan members, though they are not considered to be insured or reported as "covered lives." All utilization management is performed by the Health Plan, including efforts to increase the use of preventive care and application of utilization management criteria to care.

Basic Health Care includes the following components:

Eligibility	Adults and children up to 300% FPL, not eligible for public insurance program Must apply for Medi-Cal before allowed in program
Enrollment Strategy	At point of service, not open to residents not seeking care
Participant Costs	Sliding Scale Premiums: $0-15 per quarter for children; $0-225 per quarter for adults. No copayments
Provider Network	Contra Costa Regional Medical Center and 8 satellite health centers
Administration	Contra Costa Health Plan (a division of the Health Department)
Benefits	Doctor visits, lab, x-ray, pharmacy, specialty, inpatient hospitalization, maternity care, dental care (emergency for adults, comprehensive for children)

ATTACHMENT E
GLOSSARY OF KEY TERMS

access. A person's ability to obtain affordable medical care on a timely basis.

adverse selection. The tendency of persons with higher risk health expectations to apply for or continue insurance coverage to a greater extent than persons with lesser health risk(s).

case management. A process of identifying plan members with special healthcare needs, developing a health-care strategy that meets those needs, and coordinating and monitoring the care, with the ultimate goal of achieving the optimum healthcare outcome in an efficient and cost-effective manner.

chronic disease management. Chronic disease management (CDM) is a systematic approach to improving health care for people with chronic disease. Health care can be delivered more effectively and efficiently if patients with chronic diseases take an active role in their own care and providers are supported with the necessary resources and expertise to better assist their patients in managing their illness.

co-payment. A specified dollar amount that a member must pay out-of-pocket for a specified service at the time the service is rendered.

crowd-out. A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons or payors drop their private coverage and take advantage of the expanded public subsidy. Crowd-out also occurs when such programs act as an incentive for employers to contribute fewer dollars to employees' health insurance coverage, or altogether drop coverage in an effort to prompt employees to enroll in the new public program.

Employee Retirement Income Security Act (ERISA). A broad-reaching federal law that establishes the rights of pension plan participants, standards for the investment of pension plan assets, and requirements for the disclosure of plan provisions and funding.

health insurance. Financial protection which provides payment of benefits for covered sickness or injury.

healthcare quality. The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Medicaid. A jointly funded federal and state program that provides hospital expense and medical expense coverage to the low-income population and certain aged and disabled individuals.

Medicare. A federal government hospital expense and medical expense insurance plan primarily for elderly and disabled persons. See also Medicare Part A, Medicare Part B, and Medicare Part C.

member services. The department responsible for helping members with any problems, handling member grievances and complaints, tracking and reporting patterns of problems encountered, and enhancing the relationship between members of the plan and the plan itself.

preventive care. Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well personal care.

premium. A prepaid payment or series of payments made to a health plan by purchasers, and often plan members, for medical benefits.

primary care. General medical care that is provided directly to a patient without referral from another physician. It is focused on preventative care and the treatment of routine injuries and illnesses.

quality management (QM). An organization-wide process of measur-ing and improving the quality of the healthcare provided by an MCO.

utilization management (UM). Managing the use of medical services to ensure that a patient receives necessary, appropriate, high-quality care in a cost-effective manner.

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