San Francisco has passed an ordinance to cover basic health services for the county’s uninsured. The following summarizes the plan’s essential components:

**Who is eligible?**
All 82,000 (estimated) uninsured San Francisco residents regardless of income or pre-existing medical conditions are eligible.

**What services are covered?**
Medical services for the prevention, diagnosis and treatment of medical conditions – inpatient and outpatient hospital services, professional medical services, diagnostic and laboratory services, prescription drugs and emergency services from participating providers. Dental, vision, cosmetic and fertility services are excluded.

**Who will administer the plan?**
San Francisco Health Plan, the health plan that already manages care for Medi-Cal, Healthy Families, Healthy Kids, Healthy Young Adults and home care workers will operate the managed care plan for the uninsured.

**What providers are in the network?**
SF County hospitals and clinics, SF community hospitals, community clinics, 400 primary care providers and 1500 specialists are in the MediCal managed care network, operated by San Francisco Health Plan. The health plan will need to contract with a comparable network to assure access to coverage for the uninsured.

**What will it cost?**
The plan has been actuarially projected to cost about $200 million annually or $2,415 per uninsured.

**How much will providers be paid?**
This is to be negotiated. The plan’s projected actuarial costs are based on Medicare rates for professional services and MediCal rates for hospital care.

**How will it be financed?**
The City/County of San Francisco will pay over half ($104 million). Employers will pay through a pay or play mechanism for their uninsured workers. Projections are that at full implementation about $28 million (14%) of the plan’s costs could be borne by employers. Individuals will pay on a sliding fee scale basis; at full implementation individuals could pay for about $56 million (28%) of the plan’s costs.

**How is the employer contribution computed?**
For mid-sized employers of 20-99 employees, an employer’s contribution is $1.06 per eligible employee hour; for larger employers of more than 100 employees, an employer’s contributions will be $1.60 per eligible employee hour.

**When will it implemented?**
The plan will be phased in three phases, beginning in July 2007.

**ITUP Commentary**

*Building from strength*-  
San Francisco’s plan for the uninsured builds from its strengths—locally run managed care, a major commitment of financial resources to care for the uninsured ($104 million, over half of the plan’s costs) and a strong, vibrant local safety net (that already cares for 2/3rds of the uninsured in county clinics and free and community health centers).

*Individual contributions*-  
The composition of San Francisco’s uninsured includes a far larger percentage (55%) of individuals with incomes over 200% of FPL who can afford to meaningfully contribute towards the costs of their coverage. The expectation is that individuals will contribute, but the design of those contributions is as yet, unclear.

San Francisco’s ordinance does not have an individual mandate. A “free rider” penalty was included in the Massachusetts universal coverage legislation for those who used the state’s coverage without paying into it. This may be an appropriate added design component to be considered in San Francisco.

*Employer contributions*-  
The employer contribution is estimated to account for about 14% of the total cost of coverage, and is collected through a pay or play assessment on the medium and large sized employers of uninsured San Franciscans. Pay or play is an approach that reduces incentives for crowd-out, the possibility that employers or employees may drop existing coverage.

The pay or play approach approved by the Board of Supervisors (an hourly figure linked to the costs of health coverage for city employees) may be subject to lawsuits under a provision of ERISA (the federal Employee Retirement Income Security Act) which prohibits states from mandating the benefit packages of large self-insured multi-state employers. This has been interpreted by courts as prohibiting states from mandating that employers offer health coverage. While this may have been judicial over-reach, the Supreme Court has affirmed it. The design features of the San Francisco ordinance’s assessment are likely to be reviewed by the courts as to whether its unique provisions violate ERISA.

The courts have never ruled that a state or locality could not enact a general payroll tax, an income tax, or a sales tax to pay for health coverage for state or local residents, and it is unclear whether Congress could constitutionally bar state and local taxing authority.
The best design to avoid ERISA challenges is a payroll tax based on a percent of wages or payroll, similar to Unemployment Insurance, State Disability Insurance or Social Security taxes.

An employer mandate is only one of many possible options for employers to contribute; the goal in San Francisco is a level playing field among employers that shores up employer based insurance system.

Cost controls-
Steadily rising costs of health care and health coverage erode American business’ competitiveness, worker’s incomes, and federal, state and local budgets. The measure gives important, but limited attention to stemming rising health costs and premiums by funneling the program through the locally run managed care plan.

Access not coverage-
The plan is designated as a Health Access Plan (HAP) not as health coverage. This is an interesting and innovative concept that avoids the Catch 22 of other local coverage expansions. The interplay of federal and state laws can reduce federal and state program contributions towards care to the uninsured on a 1/1 basis in some forms of local coverage expansion. The San Francisco Plan’s design avoids that costly trap.

HAP is targeted to improve health care delivery to uninsured, reinvent the safety net, improve access within a defined network, assure every patient a primary care provider, replace the multiple (and often unknown) public and private sliding scale programs for the uninsured with transparent eligibility rules and known costs in advance of care, provide a membership card that assures access to a continuity of organized services and improve access to heretofore hard to access specialty services.

Prepared by Lucien Wulsin, 7.25.06