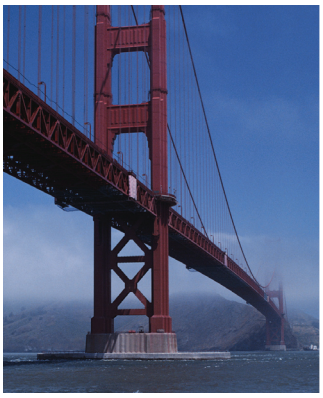
# Building a Healthier San Francisco

## Increasing Access to Health Care by Building Ties Between San Francisco Employers and Safety Net Clinics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by Peter Harbage

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# About the Author

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San Francisco policymakers are currently considering two major healthcare reform initiatives. The first, offered by County Supervisor Tom Ammiano, requires that employers contribute a set amount of money toward the purchase of "healthcare services" for employees. The second, outlined recently by Mayor Gavin Newsom, appears to be a broader proposal that would create a pool for San Francisco's uninsured to receive access to care through safety net providers.[1,2]

Central to both proposals is how employers can share in the responsibility for purchasing health care and how to best deliver that newly purchased care to employees. Supervisor Ammiano's proposal articulates a plan for employer participation, but it is silent on the care delivery system to be used. In contrast, the plan offered by the Mayor clearly articulates that the delivery system under the reform plan should be based on the existing safety net, but in its current form, the plan does not specify the role employers would play. As part of his announcement, Mayor Newsom is building a committee to address this and other critical questions.

This brief is intended to begin the discussion of how to answer questions both on employer responsibility and the design of the care delivery system. More specifically, the brief discusses how employers could join together to form a collaborative to purchase high-quality care from San Francisco's safety net providers. Under this approach, employers are given a simple administrative mechanism for fulfilling their responsibility to support employee health. At the same time, safety net clinics would offer an excellent alternative to private providers. The safety net network would also significantly benefit from the security of an employer-based income stream and could use additional funding to expand infrastructure, even during this time of tightening government budgets. Most importantly, employees would see better health outcomes from increased access to care.

Originally, this paper was drafted as a discussion document examining the use of the safety net as the sole delivery system under Supervisor Ammiano's proposal. However, the Mayor's vision for healthcare reform in San Francisco now makes this analysis even more relevant. This brief is not an exhaustive list of reform concepts, nor is it a recommendation as to the "best" reform approach. Rather, it simply presents ideas specifically designed to bring the health care purchased by the business community together with the high-quality, affordable services of safety net clinics. The concepts discussed here are compatible with a San Francisco reform plan that may or may not contain an employer mandate. It also provides options for direct purchase of care, as well as for the creation of a health insurance product.

# background

Employer-sponsored health insurance is the primary gateway to health care in the United States. Of all Californians under age 65 with health insurance, approximately 60 percent receive health insurance through a family member's employer.[3] Yet, this gateway is under strain. Over the past several years, the percentage of people with employer-sponsored insurance has fallen, and this trend is continuing. According to the 2003 California Health Interview Survey, the percentage of Californians under age 65 in employer-sponsored insurance fell by 2.6 percent from 2001 to 2003.[4] Even for employers who want to offer insurance, cost and complexity are major deterrents. In California, health insurance premiums have skyrocketed by over 60 percent from 2000 to 2004.[5]

Of the 6.6 million Californians under age 65 without health insurance in 2003, an estimated 83,000 lived in San Francisco County.[6] The vast majority of these persons appear to be adults, with the uninsurance rate for those age 18 and under at less than 1 percent.[7] The Institute of Medicine (IOM), an arm of the National Academy of Sciences, has described the high costs of being uninsured. Those who are uninsured typically delay, or even forgo, needed care because it is unaffordable. This delay can lead to unnecessarily prolonged illnesses, developmental losses for children, financial stress and even premature death.[8]

In addition, uninsurance leaves families at tremendous economic risk. Half of all personal bankruptcies are related to medical bills.[9] Societal costs of being uninsured include lost economic productivity from avoidable illness and death, increased government costs to expand public health system capacity, and unnecessary reliance on expensive emergency room care.[10] Also, there is the hidden cost-shifting between those who pay for health insurance and those who do not. Health insurance status is a major predictor of health status.

San Francisco's community clinics are uniquely well suited for treating the uninsured population with the high quality care that they need and deserve. The San Francisco Department of Public Health operates over 20 clinics in conjunction with affiliated partners. Known as the Community Health Network, these clinics offer a wide-array of services beyond primary care, including dental care, mental health services, nutritional classes, and chronic care. The care offered is culturally sensitive, which is appropriate to the diversity of San Francisco's workforce. Some clinics already operate during evening hours and on weekends, something not true of most private physician offices and clinics. In addition, most San Francisco clinics are easily accessible by public transportation.[11]

# Goals for Building Employer-Clinic Partnerships

By building on the clinic system, all three stakeholders – employers, employees and their dependants, and community safety net clinics – could all significantly benefit. Employers can help take responsibility for the health care of their employees and improve productivity by creating a healthier workforce. Employers should see reduced presentism (those employees who show up sick and are thus non-productive workers) and absenteeism. At the same time, employees would see improved health status and quality of life from increased access to care. And finally, community health clinics would be strengthened overall by a steady source of additional funding from private sources. The additional funds would provide an opportunity to further expand existing programs.

### In developing these concepts, the following goals were used as a benchmark for success:

- Improved health status and quality of life for participating employees;
- Stable, predictable healthcare costs to employers;
- Increased funding and capacity for community health clinics;
- Improved economic performance for the county through a healthier, more productive workforce;
- Protection of employee medical privacy;
- Creation of options for additional federal or state support for San Francisco County; and
- Increased stability in the overall safety net care system.

# Employer-Clinic Partnership Options

This section discusses the two primary approaches to achieving the above goals.

### Direct Services Purchasing

- Create a purchasing collaborative for primary care
- Create a purchasing collaborative for a disease management program
- Promote wellness

### Insurance Approaches

Health insurance is the most effective way to assist in improving health status.[12] At the same time, purchasing insurance can be administratively burdensome and expensive for employers. As a result, policymakers may want to consider a direct purchasing option.

# Direct Service Purchasing Options

The direct purchase of health services by employers from safety net clinics is a relatively new concept. Through the Local Initiatives and fee-for-service options, Medi-Cal has long been leveraging the services of this provider group.

### Create a Purchasing Collaborative for Primary Care

Under this option, businesses would join together to create a new purchasing collaborative, perhaps formed as a non-profit, to coordinate the purchase of health services from local safety net clinics for employees and their dependents.[13]

The collaborative and the clinics would agree upon a set of services to be purchased by the

employers at a fixed price. The collaborative would negotiate prices and create a system of eligibility that could be easily used by clinics. The collaborative would help distribute information on the availability of clinic services so that employees could obtain care as needed. This plan protects employee confidentiality by creating firewalls to prevent the sharing of inappropriate information between the collaborative and employers. There are other benefits to a purchasing collaborative, such as the possibility of foundation support for developing a new and innovative idea and the possibility of earning tax breaks – though both of these concepts would need additional development.

Of course, by using an administrator, small businesses can also receive help navigating the health care system. Many employers, particularly small businesses, have cited administrative complexity as a leading reason for not purchasing insurance.[14] The San Francisco Health Plan is one entity that could administer the purchasing collaborative, though there are several challenges to using SFHP. For example, ensuring compliance with state regulations under the Department of Managed Care, such as the Knox-Keene benefits rules, may prove difficult. While SFHP would not offer an insurance product under this option, licensing concerns could be raised by the state. Nonetheless, these challenges may actually be easier to overcome than building a new entity from the ground up. In addition, these challenges would be easier to overcome than those posed by other direct purchase options which place the burden on the individual to act, such as health savings accounts.[15]

One of the critical questions for a collaborative is how to design the benefit package. Adults in San Francisco can already use clinic services at free or reduced cost, regardless of employment status, assuming they qualify for the sliding scale program.[16] In addition, clinic-based care, as a general rule, is episodic in nature and delivered with little coordination. Therefore, a program is needed that provides employers with certainty in the services they purchase and establishes a medical home for employees. The employers and clinics would need to agree on a set of benefits that would likely include services already offered (primary care and available specialty care) in addition to services not already offered. Additional services might include:

- Same day appointments available at convenient times for workers;
- 'Medical Home' services;
- A set schedule of diagnostic and preventative care; and
- Access to otherwise unavailable or difficult to obtain specialty services, such as dental care.

Steps will need to be taken to be able to ensure capacity for the influx of new patients into the clinic system. One way to address this is through a phase-in approach where the County could bring in new individuals in groups over time and developing infrastructure along the way.

In terms of financing, all participating employers would share the financing of this program by paying a flat fee to the collaborative, based on the number of employees enrolled. This method spreads the program's costs among all participating employers, just as a risk pool would if this were an insurance product. The collaborative would need to develop an appropriate per person cost across all participating employers. The collaborative could also develop a sliding scale cost-sharing plan for employees.

There is every reason to believe that the collaborative approach is scalable and could offer additional services. For example, the collaborative could be a point of entry to other health insurance programs by helping those

eligible for public health insurance programs to enroll. Also, a larger benefit package could be offered, such as one including inpatient services delivered by safety net hospitals.

### Create a Purchasing Collaborative for a Disease Management Program

Based on the purchasing collaborative for primary care, this approach would focus exclusively on disease management. Employers could contract with local clinics for provision of disease management services for workers and their dependants with chronic illnesses. Services would include an extensive package of care that includes: primary care visits, specialist visits, diagnostic testing, support group meetings, prescription drugs needed to manage the diseases, and transportation to clinics for obtaining care. Employees with different treatment needs (for asthma, diabetes, high cholesterol, etc.) could be enrolled in different care programs at differing price points. The San Francisco Community Health Network already has already had success with disease management for diabetes.[17]

There are many benefits to this approach. Although such a program would not offer comprehensive benefits (the best possible outcome for the uninsured), it could still offer much needed care to employees. Estimates vary, but as much as 80 percent of health care costs are from 20 percent of the population.[18] Many of the 20 percent have chronic disease like diabetes and asthma that are currently poorly controlled. For the uninsured, some rely on the emergency room to treat their condition when it deteriorates. But, if San Francisco County were to have an expanded effort to teach commonsense disease management techniques and to improve access to such care, then affected employees would see their quality of life increase and healthcare costs would be reduced.[19] There could also be a benefit to the city and county budget as the number of frequent users of public health services is reduced through increased preventative and chronic care.[20]

In a recent survey of healthcare opinion leaders, disease management techniques were identified as the most effective approach for reducing otherwise unnecessary use of the healthcare system.[21] In a time of limited funds, and with Supervisor Ammiano revising his proposal to seek fewer dollars from the employer community,[22] a disease management approach could be a cost-effective strategy for moving forward.

This approach could easily be taken in conjunction with the primary care model outlined above. In fact, the collaborative could be designed to address those with both primary care and chronic disease needs.

### Promote Wellness

The collaborative could also take on a wellness promotion function. For example, the collaborative could assist employers and employees in adopting healthy lifestyles. As a result, participating employers are likely to see increased productivity and reduced absenteeism.

The collaborative, with contract support from the safety net clinics, might offer coordination and technical assistance to employers implementing such programs. Safety net clinics could help develop, implement, and monitor wellness programs. Even if clinics had to develop additional infrastructure to do this for the larger caseload that would occur under this proposal (for example, by hiring health educators or dieticians), there is still reason to believe this could be a useful source of stable revenue for clinics.

The collaborative could also serve as a clearinghouse for successful wellness approaches from around the country. Some companies offer workers financial rewards for exercising, dieting, and engaging in other healthy behaviors. Still other firms have started onsite fitness programs and are paying for gym memberships. Specific examples of these types of programs include:[23]

- Employers in Las Vegas worked with unions to improve wellness. In exchange for improving health behaviors, such as reducing smoking and obesity, employees were offered various incentives, including paid leave.
- Fairview Health Services (Minneapolis) gives gift certificates of up to $100 for workers who take part in health programs.
- HCA, the nation's largest hospital chain, asserts that it saved $2.76 for every $1 it invested in employee wellness programs. For example, HCA offered cash incentives to each employee who completed a weight-management program.

# Insurance Options

In contrast to the direct service purchasing options, it is possible to promote insurance enrollment as a means of increasing funding to community safety net clinics.

### Develop a New Insurance Product

Under this option, employers could develop a new product with benefits and services that are delivery-limited to services provided by local public clinics. In order to fulfill the applicable government regulations, a partnership would need to be formed with an existing insurance provider. Or, it may be possible to create a new government program.

An insurance program would likely be significantly more expensive than the direct services option. To help control costs for employers and employees, policymakers could design a benefit package that offers less than a comprehensive benefit package; for example, a product that lacks an inpatient benefit. Or as another example, policymakers could create a high-deductible health plan to protect families against catastrophic illness. Finally, it may be possible that the program could be designed as a government program or as a pilot program that might not need to meet all California regulatory requirements (meaning that it could be a managed care plan with a reduced benefit). Given that San Francisco appears to have reached universal health insurance for children, however, the focus should be on providing coverage to adults.

The program should be open to San Francisco employers, but there will need to be protections taken against adverse risk selection. Absent such protections, the insurance product could quickly fail.

Though it should not be a controlling factor, it is worth noting that those with private health insurance typically seek care from providers other than community safety net clinics – a fact that could have a significant negative financial impact on clinics (and safety net hospitals) if there is a major increase in the number of San Franciscans with private health insurance.[24] The financial impact of creating more insured on the local level is an important factor to consider when deciding on a service delivery model for those who are newly insured, given that employees could still receive high-quality care through safety net clinics.[25]

## Medi-Cal Options with Insurance Products

As a long-range option, it may be possible to follow an insurance approach leveraging federal dollars. For example, the Muskegon County, Michigan "Access Health" program uses federal money to help pay for insurance. Under this county-run program, employers pay a third of the cost of a health insurance premium, with employees and the community both paying a third. The community share comes from Disproportionate Share Hospital (DSH) payments that otherwise went to the local safety net hospital under Michigan's Medicaid program. Another possibility would be to devise a Medi-Cal expansion that could cover the currently uninsured with primary care services. In 2002, the state of Utah created such a program.[26] With the creation of the Coverage Initiative under the 2005 Medi-Cal hospital waiver, the state has the flexibility to make Medi-Cal funds available to support a health reform effort in San Francisco.[27]

Under any scenario, a Medi-Cal expansion specific to San Francisco would take significant time to develop and would require cooperation from both the state and federal government.[28] Even if a Medi-Cal expansion is not used, both the Michigan and Utah program could offer valuable lessons for San Francisco policymakers on the impact of expanding access to primary care.

## Promote Enrollment in Healthy Kids, Healthy Families and Medi-Cal

In California, more than half of all uninsured children are eligible for either Medi-Cal or Healthy Families. The San Francisco Health Plan undertakes extensive efforts to enroll and retain children in public health insurance programs,[29] and San Francisco has enjoyed significant success in reducing the number of uninsured children.[30] However, there is no available analysis on the percentage of adults eligible and but not enrolled in Medi-Cal. Therefore, employers could take proactive steps to educate their employees about available programs. Under SB 23 (Midgen), the state of California would have developed a notice to be given to all employers to inform employees about public health insurance programs. While Governor Schwarzenegger vetoed this bill saying that it was not "strategically designed" in its effort to enroll additional eligible persons,[31] the concept is applicable at a county level.

## PacAdvantage Option

Another option for expanding access to health insurance for small businesses is to promote the use of California's small business purchasing pools, such as PacAdvantage. While potentially helpful, this concept is not discussed here since the PacAdvantage private insurance offering would not necessarily increase support for safety net providers.

# Footnotes

[1] This brief was in final production as Mayor Newsom made his policy announcement on San Francisco's uninsured on January 31, 2006. This brief has been updated as of February 1, 2006.

[2] Rachel Gordon, "Newsom's plan boosts health care for the uninsured," *San Francisco Chronicle*, February 1, 2006. *San Francisco Chronicle*, "Working together on health care," Editorial, January 30, 2006.

[3] E. Richard Brown and Shana Alex Lavarreda, "Job-based Coverage Drops for Adults and Children but Public Programs Boost Children's Coverage," UCLA Center for Health Policy Research, February 2005.

[4] Ibid.

[5] California Department of Insurance, "Priced-Out: The State of California Health Care," 2005.

[6] A much smaller number would actually be affected by the employer mandate plan proposed by San Francisco County Supervisor Ammiano, who has cited 38,000 workers being affected by the mandate. Also, please see: City and County San Francisco, Office of the Controller, *City Survey 2005*, 2005. "Most of the 13 percent of respondents without health insurance are employed at least part-time, between 30 and 60 years old, and describe themselves as Asian or white. Half of respondents who say they are uninsured work full time."

[7] California Health Interview Survey, 2003, downloaded January 15, 2006.

[8] Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America," National Academy of Sciences, 2003.

[9] Himmelstein et al, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* Web Exclusive, February 2, 2005.

[10] Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America," National Academy of Sciences, 2003.

[11] For more information on San Francisco's clinics and community health centers in general, please see: Community Health Network of San Francisco, http://www.dph.sf.ca.us/chn/; The California Primary Care Association, http://www.cpca.org/index.cfm; Jessamy Taylor, "The Fundamentals of Community Health Centers," National Health Policy Forum, August 2004.

[12] Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America," National Academy of Sciences, 2003.

[13] Supervisor Ammiano's proposal does not have a direct affect on dependant coverage, though there is research to support the idea that parents with coverage are more likely to obtain coverage for children.

[14] According to employer surveys, cost is always the top reason for not offering insurance. Administrative complexity is also frequently cited as a barrier. Please See: Jon R. Gabel et al., "Annual Survey of Employer Sponsored Health Benefits," Kaiser Family Foundation and Health Research Education and Trust, September 2001. William M. Mercer Inc., "Employer Sponsored Health Insurance: A Survey of Small Employers in California," California HealthCare Foundation, August 1999. King, Brown & Partners, "Small Business Employer Sponsored Health Coverage Qualitative Report," California HealthCare Foundation, September 2000.

[15] California Department of Insurance, "Dangerous Prescription: An Assessment of Health Savings Accounts and Their Impact on the Health Care System," January 2006.

[16] Subsidies phase out at 500 percent of poverty.

[17] San Francisco Department of Public Health, Annual Report, Fiscal Year 2004-2005.

[18] California Health Policy Forum, "Macro Health Policy Trends" Seminar, Sacramento, California, January 19, 2006.

[19] Please see the Frequent Users of Health Services Initiative at www.csh.org

[20] Ken Thorpe, "The Rise in Health Care Costs and What to do about it," *Health Affairs*, Nov/Dec 2005. For a series of case studies, please see California HealthCare Foundation, "The Role of Community Pharmacies in Diabetes Care," July 2005.

[21] Commonwealth Fund, "Health Care Opinion Leader Survey," April 2005.

[22] Charlie Goodyear, "Ammiano says he'll deal on health care," *San Francisco Chronicle*, January 27, 2006.

[23] All examples taken from: California Department of Insurance, "Priced-Out: The State of California Health Care," 2005.

[24] Medi-Cal and the uninsured constitute 89 percent of the patients at California's community health centers and account for 84 percent of the revenue. In contrast, private insurance patients constitute just 6 percent of the patients and account for 6 percent of revenue. For more information, please see: California HealthCare Foundation, "Medi-Cal Facts and Figures," January 2006. The 2003 data is from California Office of Statewide Health Planning and Development.

[25] Though beyond the scope of this paper, an increase in the number of insured persons using public hospitals (and affiliated clinics) could actually lead to a reduction in Medi-Cal payments to the County since higher insurance rates could reduce access to Medi-Cal Disproportionate Share Hospital funding.

[26] For more information, please see: State Coverage Initiatives, "Utah's Primary Care Network," February 2003.

[27] Andy Schnider and Peter Harbage, "The Three Waivers: Medicaid Hospital Financing in California, Iowa, and Massachusetts," California Health Policy Forum, August 2005.

[28] For more information, please see: Paul Fronstin and Jason Lee, "A Community Expands Access To Health Care: The Case Of Access Health In Michigan," *Health Affairs*, May/June 2005.

[29] San Francisco Health Plan, "Health Coverage Programs for Children, Youth, & Young Adults in San Francisco," Report to the San Francisco Health Commission, August 3, 2004.

[30] City and County of San Francisco Department of Public Health, "Annual Children's Health Coverage Report," September 13, 2005. San Francisco Health Plan, "San Francisco Achieves Over 99 percent Health Care Coverage Rate for Children," Press Release, October 11, 2005.

[31] Office of Governor Arnold Schwarzenegger, "SB 23 Veto Message," October 2005.

# conclusion

This paper outlines several ideas to strengthen employer ties to safety net clinics in San Francisco County. These approaches could significantly benefit all three stakeholder groups considered – employers, employees and their dependants, and safety net clinics. Employers can help take responsibility for the health care of their employees and at the same time improve productivity by creating a stronger workforce. Employees would have greater health status and improved quality of life. And finally, local safety net clinics would be strengthened by increased funding, thereby helping the community at large. All of this could be achieved while still protecting the medical privacy of employees.

Among these ideas are approaches that increase health care through direct purchase options and through insurance coverage options. Both approaches have trade-offs, but the academic research clearly shows that enrollment in health insurance is the most effective way to increase health status. Insurance can be administratively complex with high and unpredictable costs. Clearly, the research shows that the best case would be for all the uninsured to be enrolled in a comprehensive insurance plan. But in a time of limited resources, a widely-available disease management program could offer the greatest positive results (improved quality of life and budget savings) for the investment. And the County should always be on the lookout for opportunities to increase enrollment in public programs. All concepts discussed here would need more operational detail before implementation, with a critical aspect of such work being careful consultation with stakeholders to determine what is appropriate for the community.

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