Healthy San Francisco

A Case Study of City-Level Health Reform

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About Community Catalyst

Community Catalyst is a national non-profit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

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Introduction

Healthy San Francisco (HSF) is an innovative attempt to address the problems of the uninsured at the local level. The development of Healthy San Francisco illustrates key factors in the development of health reform that are relevant not only at the local level but also at the state and even national level. The factors that contributed to the success of Healthy San Francisco include political leadership, a strong delivery system foundation on which to build, strong community support and the availability of state and federal funding.

This paper examines the way the program operates, how it came to pass and what lessons there may be for other cities and counties. The first section provides a brief background of the development of Healthy San Francisco. The second section is a summary of Healthy San Francisco, including key points about financing, eligibility, premiums and point of service fees. This section also discusses the issue of the affordability of the program from the enrollee point of view. The third section reviews the political challenges the plan faces. The conclusion addresses the lessons that San Francisco holds for other health reform efforts.

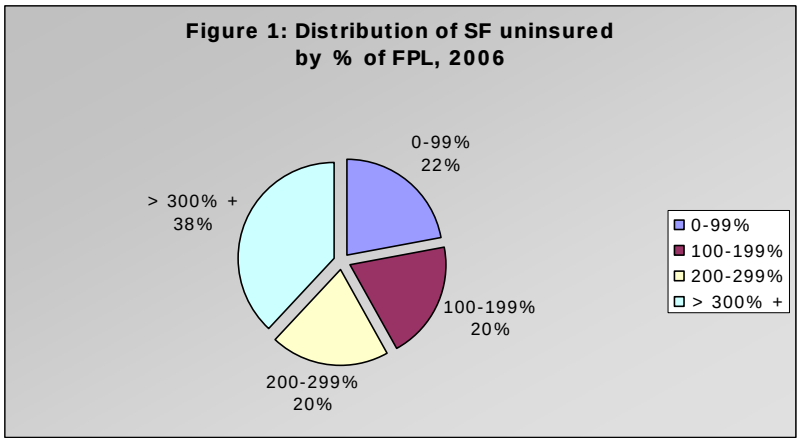
I. Background history

1. Issue of the uninsured

Healthy San Francisco is the culmination of a multi-year effort to address the problem of the uninsured in San Francisco. Starting with "Measure J: Universal Health Care Declaration of Policy City of San Francisco" in 1998 (64.6 percent yes votes),[1] the city and county have passed several ordinances to expand health care coverage to children and provide affordable and preventative health care services to certain young and low-income parents, employees of city and county contractors and the uninsured.[2] However, despite the city's efforts, the 2003 California Health Interview Survey shows that approximately 15 percent of San Francisco's population is uninsured (82,000 San Franciscans of ages 18-65). Most of the uninsured lacked access to employer sponsored insurance and had low or moderate incomes. *(See Figure 1)*

[1] For more information, visit: http://www.smartvoter.org/1998nov/ca/sf/meas/J/

[2] Additional ordinances included, Healthy Workers, Healthy Kids and Young Adults, and Health Care Accountability



2. The development of Healthy San Francisco[3]

Healthy San Francisco was built on the foundation of the existing health care safety net which includes both a large number of primary care clinics and San Francisco General Hospital. The San Francisco Department of Public Health estimated that each year the department spends at least $20 million in providing care to people who are employed but uninsured, mostly through the hospital.

In November 2004 Proposition 72, a statewide "pay or play" health reform bill passed by the legislature and signed by Governor Gray Davis, was overturned at the ballot by a slim margin, but received overwhelming support from 70 percent of voters in San Francisco. Supervisor Tom Ammiano saw the strong support for the state law as a political opportunity. He started exploratory talks with key allies about how to move toward universal health care in San Francisco. In February 2006, with strong support from labor unions and community organizations, Ammiano proposed the San Francisco Health Care Security Ordinance (HCSO), which included a minimum employer health spending requirement and a public option. Considered as a step towards universal healthcare, the ordinance was carefully crafted to withstand an ERISA challenge *(See pages 9-11)* and was unanimously passed by the Board of Supervisors and signed by Mayor Gavin Newsom in August 2006.

In supporting the employer spending requirement, the Board of Supervisors and the mayor articulated three basic principles:

1. A broad expansion of public coverage without any shared responsibility requirement for employers could lead to significant crowd-out (i.e. the replacement of private coverage with public coverage) over time as low-wage employers coming into the market stopped offering coverage, which would overwhelm the public system;
2. The employer spending requirement would level the playing field between employers, helping to stem the decline in job-based coverage; and
3. Provide a source of revenues for the expansion.

[3] This part was written based on the information provided by Jessica Rothhaar from Health Access California and Ken Jacobs from UC Berkeley Center for Labor Research and Education

The requirement did not apply to small businesses with fewer than 20 workers. The requirement on businesses with 20-99 employees was roughly equivalent to half the average individual premium cost in California *(See more details on employee eligibility and employer contribution fee on page 7).*

At the same time as the San Francisco Health Care Security Ordinance was being developed, Mayor Gavin Newsom created the Universal Healthcare Council (UHC) to forge a consensus among a wide range of stakeholders, including representatives from health care, business, labor, advocacy organizations, philanthropy, research and other disciplines, to achieve universal coverage *(See attachment on page 13 for the list of UHC members).* He brought forward a proposal from Mitch Katz, director of the San Francisco Department of Public Health, to reorganize the public health delivery system and create a city-wide health access plan. Ultimately the key players saw great value in bringing the two concepts together into a single coherent package: the health access program needed the spending requirement to avoid crowd-out and it provided a good low-cost option for small-and medium-sized businesses not providing coverage. As a result, Healthy San Francisco was born and introduced on April 2007.

3. Key players and the role of labor unions and community organizations[4]

Alongside Supervisor Ammiano, labor unions and community organizations such as Health Access, Senior Action Network, California Women's Agenda, and the Bay Area Organizing Committee played major roles in the policy development and negotiations and in helping to drive the process forward. The SF Worker Health Coalition collected stories about uninsured workers' struggle for health care.

The coalition grew to include the Association of Community Organizations for Reform Now (ACORN), San Francisco Organizing Project (SFOP), the Bay Area Organizing Committee and Health Care for All SF as well as other labor and nonprofit groups. These organizations mobilized their membership and held public events in support of the HCSO. They also worked to secure the support from Newsome, who was being heavily lobbied by the Golden Gate Restaurant Association and other employer groups to oppose the ordinance. Ultimately, the ordinance passed the Board of Supervisors with a veto-proof margin and was signed by the mayor. *(See attachment on page 14 for the chronology of the development of HSF)*

II. Healthy San Francisco (HSF)

1. Summary[5]

HSF started its first phrase on July 1, 2007, and the initial funding is projected to last for three years. The program is designed as a restructuring of the county's health care safety net, emphasizing providing primary care and prevention for participants through medical homes.

Administration

[4] This section was written based on the information provided by Jessica Rothhaar from Health Access California and Ken Jacobs from UC Berkeley Center for Labor Research and Education

[5] To obtain the full regulation, click the link: http://www.healthysanfrancisco.org/about_us/Reports.aspx

The San Francisco Department of Public Health oversees the overall administration of HSF. Its responsibilities include: overseeing the development and implementation of the plan, ensuring adequate financing and evaluating the plan's effectiveness.

Estimated cost

To provide health care services to 82,000 uninsured San Francisco residents, HSF is expected to cost nearly $200 million for the first year. This projection is based on the reimbursement rate of Mixed Medi-Cal / Medicare Rate in 2006 (Monthly Rate: $201.25 per person; Annual Rate: $2,415 per person).

Financing

The plan is primarily financed by redirecting existing county funds for the care of the uninsured, which totaled approximately $123 million in 2007. In addition, the program is expected to receive an annual $20 million from existing federal and state health programs and $24 million per year over three years from the Health Care Coverage Initiative Fund. Officials from the city and the Department of Health hope that these funds will be maintained after three years since they come from California's ongoing hospital waiver. Participants and employers will contribute approximately $34 - $44 million per year through the participation fee, the point-of-service fee, and the employer mandate.

Table 1: Projected annual revenues	**$**
Health Care Coverage Initiative Funds	$24M
City and County Funds for the care of the uninsured	$123M
Existing funds federal and state health programs	$20M
Employers' contribution	$30M - $40M
Participants' fee	$4.75M
Point-of-service fee	$0.05M
Total	**$201.8 - $211.8**

Estimated enrollment

HSF was launched in July 2007 at two health centers, Chinatown Public Health Center and North East Medical Services and expanded to 20 clinics in September 2007. The plan spread citywide in January 2008. As of July 14, there were about 25,000 people signed up for the program.[6] The city officials hope to enroll 45,000 uninsured in the first year. By the third year, enrollment is expected to be 60,000, or 82 percent of the uninsured.[7]

Eligibility

HSF is designed to expand health care access to uninsured adults aged between 18 and 64 years who reside in San Francisco, regardless of their employment status, immigration status, or pre-existing health conditions. However, during the online application, those who are eligible for

[6] http://www.healthysanfrancisco.org/about_us/

[7] Katz, Mitchell H. (January, 2008), "Golden Gate to Health Care for All? San Francisco's New Universal-Access Program." In the New England Journal of Medicine: Vol. 358:327-329, No. 4. Link: http://content.nejm.org/cgi/content/full/358/4/327?query=TOC

federal and state programs, such as Medicaid, are identified and enrolled in appropriate programs. Others who are not qualified for such programs are enrolled in HSF.

To be eligible for HSF, an applicant must be:

1. A San Francisco resident who can provide proof of residency
2. A current patient with an existing appointment at any of the 27 participating clinics
3. Uninsured for at least the past 90 days
4. Not eligible for public insurance program such as Medi-Cal, health families, or Healthy Kids & Young Adults
5. Between the ages of 18 and 64

Eligibility for employees whose employers who choose to participate in the program is determined under the HCSO, Chapter 14 sections 14.1 through 14.8.[8] In summary, to be eligible for HSF, employees must fulfill the following requirements:

1. Perform at least 90 days of work for an employer located in San Francisco and receive a minimum wage (an hourly rate of $9.36) determined in the Minimum Wage Ordinance, Chapter 12R of the San Francisco Administrative Code.[9]
2. Minimum working hours:

    - Work at least twelve hours per week by December 31, 2007
    - Work at least ten hours per week from January 1, 2008 to December 31, 2008
    - Work at least eight hours per week from January 1, 2009.

However, certain classifications of employees are exempt from HSF, including employees who are managers or supervisors earning more than $76,851 in 2008 and employees who are covered by Medicare or TRICARE.

Application process

The program rolled out in three stages. During the debut period (July to September 17, 2007), HSF enrolled only those with an annual income level at or below 100 percent FPL, who met the eligibility requirements. On November 27, 2007, uninsured residents with an annual income level at or below 300 percent FPL started to sign up. Currently, the program still remains open only to individuals earning up to 300 percent FPL. City officials have no definite timeline for expanding the program to uninsured at all income levels. Pressing for a definitive answer from city officials has become a main focus for community organizations and coalitions including San Francisco Organizing Project.

Applicants must make appointments with a participating medical home to meet with a Certified Application Assistor, who then completes and submits the HSF application. Required

[8] Full text of The San Francisco Health Care Security Ordinance was passed July 2006: http://laborcenter.berkeley.edu/healthpolicy/sf_ordinance.pdf

[9] For more information on the Minimum Wage Ordinance, Chapter 12R of the San Francisco Administrative Code, click: http://sfgov.org/site/uploadedfiles/olse/mwo/MWOrdinance.pdf and http://www.sfgov.org/site/uploadedfiles/olse/mwo/MWO_2008_FAQs_-_English%20_12-18-07.pdf

documents include: (1) personal identification; (2) San Francisco residency verification; (3) all family income verification; and (4) all family assets verification.

In order to maintain their membership, participants have to re-establish their eligibility every year.

Benefits

Because HSF is not a health insurance, participants are not covered outside the city's boundaries. Its coverage emphasizes preventive care. Benefits include:

1. Preventive & routine care
2. Specialty care
3. Urgent care (only at San Francisco General Hospital)
4. Emergency care (only at San Francisco General Hospital)
5. Ambulance services (only for transportation for emergencies within San Francisco)
6. Hospital care (only at San Francisco General Hospital)
7. Alcohol and drug abuse care
8. Laboratory services and tests
9. Mental health care
10. Family planning
11. Durable medical Equipment
12. Prescription medicine

Dental and vision care are not included in the plan. However, participants are encouraged to get regular screenings and check-ups.

Network providers

Table 2: Quarterly Participation Fee

FPL	Quarterly participation fee for each family member
0-100% FPL	$0
101-200% FPL	$60
201-300% FPL	$150
301-400 FPL	$300
401-500% FPL	$450
>500% FPL	$675

The services are provided by a network of local providers, primary public health department providers, community health clinics and San Francisco General Hospital. There are 27 medical homes participating in HSF. Recently, three private not-for-profit hospitals in San Francisco (including California Pacific Medical Center, St. Francis hospitals and St. Mary's Hospitals) have agreed to treat 25,000 participants of Healthy San Francisco. Depending upon on their income, participants pay up to $250 per hospital admission under the agreement, all of which will go towards the Healthy San Francisco Fund (San Francisco Chronicle, July 11th 2008).

Participation fee and point-of-service fee

Membership and point-of-service fees are based on a sliding scale. Any person with an annual household income between 0 and 500 percent FPL is eligible for a subsidy for the participation fee determined by the Department of Public Health. Those with annual income at or below 100 percent FPL do not pay any fee while others, depending upon their income level, contribute from $60 to $450 per quarter for their membership. The point-of-service fee is $10 per clinic visit and they will pay $200 per inpatient stay. Employees whose employers participate in the program receive a discount of 75 percent off the participation fee. If the result of the discount is less than $50 per quarter, they are eligible for a waiver.

Table 3: Point of Service Fee

Services	100% of FPL	101-500% of FPL	>500% of FPL
Outpatient primary care	0	$10	$20
Specialty care	0	$20	$50
ER	$25	$50	$100
Urgent	0	$20	$50
Pharmacy	0	$5/$25	$25/$50
Ancil/Rad/PT/OT	0	$20	$50
Same day surgery	0	$100	$200
Hospitalization	0	$200 per admission	$ 350 per admission

Table 4: Employer Health Care Expenditure Rate Schedule

Business Size		January 1 2008	April 1 2008	January 1 2009
Large	**100 employees**	$1.76/hr		$1.85/hr
Medium	**50-99 employees**	$1.76/hr		$1.23/hr
	20-49 employees	Not Applicable	$1.17/hr	
Small	**1-19 employees**	Not Applicable		

Employer's contribution

HSF is also open to employees working at least 10 hours per week whose employers choose the program as part of a minimum employer health care spending requirement. Employers may choose the city option (*Healthy San Francisco* and Medical Reimbursement Accounts) to comply with San Francisco's Health Care Security Ordinance (HCSO).[10] Those who choose the city option pay a fee of $1.17 per hour per employee. On April 2008 the spending requirement extended to employers with at least 20 employees. In the beginning of 2009, the employer's contribution fee will be increased by 5 percent annually to accommodate inflation. Non-profit organizations with less than 50 employees are exempt from the spending requirement.

The employers' payments are deposited in either HSF or Medical Reimbursement Account. If employees are San Francisco residents and eligible for HSF, they may also receive a 75 percent discount on quarterly participation fees (as shown in Table 5).

If employees are not eligible for HSF or are not San Francisco residents at the time they apply, they can request that the funds be transferred to an individual Medical Reimbursement Account that can be used for

Table 5: Quarterly Participation Fee for Employees

FPL	Quarterly participation fee for employee
0-100% FPL	$0
101-200% FPL	$0
201-300% FPL	$0
301-400 FPL	$75
401-500% FPL	$113
> 500% FPL	$169

[10] For more information about complying with the Health Care Security Ordinance, including how to satisfy reporting requirements, visit: San Francisco Office of Labor Standards Enforcement (OLSE).

out-of-pocket medical expenses. In addition, employees who voluntarily sign a waiver for the year verifying that they receive health care coverage elsewhere are also exempt from the health care expenditure requirement.

Point of service fees for employees are the same as above (Table 3)

According to information from Mayor Newsom's communications office dated May 1, 2008, a total of 734 local employers decided to provide health care to their employees through the Healthy San Francisco program, contributing over $6 million toward health care expenditures and benefiting 12,900 workers. However, several restaurants increased their menu price by adding 3.5-5 percent surcharge as a "San Francisco health ordinance fee."[11] Although this was done as a form of protest, anecdotal evidence suggests that the fee was accepted and even embraced by many restaurant patrons.[12]

2. Evaluating the affordability of Healthy San Francisco

If the purpose of HSF is to protect people from the financial strain associated with illness, we conclude that the program is largely, but not entirely successful. Some low and moderate income people may still have difficulty affording their participation and point-of-service fees. According to Carroll et al. (2007),[13] most families living in California need to earn at least 200 percent FPL to pay for basic living costs other than health care. However, people living in parts of the state where housing costs are relatively high such as San Francisco and Santa Cruz, need even higher incomes (259 percent FPL or about $2,208 per month) to be self-sufficient. As a result, people whose income is between 101 – 259 percent FPL are likely to find the HSF participation and point-of-service fees burdensome and may be deterred from enrolling.

The participation fee seems affordable for those with income between 260 and 400 percent who pay a participation fee of less than 4 percent of family income.[*] However, for people with chronic illness who need ongoing medical treatment, the point-of-service costs will still constitute a significant financial strain, especially for those whose income is just above 300 percent FPL. For example, the scenario below shows the minimum monthly medical cost of a single person with Type 2 diabetes broken down by income level. People with income between 260 – 300 percent FPL barely afford the total medical cost.[**] However, those with income at 301 percent FPL would have to pay at least 6.12 percent of their income to cover their monthly medical costs. Note that this example does not apply to individuals whose employers choose to pay into the program.

[11] The Wall Street Journal, May 06, 2008

[12] Personal Communication Between Mitch Katz and Community Catalyst Deputy Director Susan Sherry on July 31-August 1st 2008

[13] Carroll, David et al (August, 2007), "What Does It Take for A Family to Afford to Pay for Health Care?" California Budget Project. Link: http://www.cbp.org/publications/pub_health.html

[*] This figure is suggested by Christine Barber and Michael Miller (April, 2007) in "Affordable Health Care for All: What Does Affordable Really Mean." Community Catalyst, Inc. Link: http://www.communitycatalyst.org/resources/states?id=0021

[**] The monthly budget for a single person living in San Francisco to spend on healthcare is $113, as reported by Carroll, David et al (August, 2007).

Scenario: Persons with diabetes use health care services more frequently. For example, a 23-year-old man with type 2 diabetes mellitus was hospitalized at least once last year. Every day he takes at least three medications (monthly supply). He makes at least six doctor visits every year. Annually he has two different types of lab tests. His annual point of service cost is $680 ($56.66 per month).

Table 6: Minimum annual cost of point of services with type 2 diabetes mellitus

Services	**101-500% of FPL**
Outpatient primary care	$10 x 6 = $60
Specialty care	
ER	
Urgent	
Pharmacy	($5 +$5 + $20) x 12 = $360
Ancil/Rad/PT/OT	$20 x 3 = $60
Same day surgery	
Hospitalization	$200
Total annual cost	**$680**
(Monthly cost)	**$56.66**

Table7: Minimum medical cost as percentage of income paid by a single person with type 2 diabetes broken down by income level

Income		**Participation fee**		**Point of service fee**		**Total medical cost**	
FPL (%)	**Income ($)**	**Monthly participation fee ($)**	**% of income**	**Monthly point of service fee ($)**	**% of income**	**Total medical cost ($)**	**% of income**
100%	$ 851.00	$ -	0.00%	$ -	0.00%	$ -	0.00%
101%	**$ 859.51**	**$ 20.00**	**2.33%**	**$ 56.66**	**6.59%**	**$ 76.66**	**8.92%**
200%	**$ 1,702.00**	**$ 20.00**	**1.18%**	**$ 56.66**	**3.33%**	**$ 76.66**	**4.50%**
201%	**$ 1,710.51**	**$ 50.00**	**2.92%**	**$ 56.66**	**3.31%**	**$ 106.66**	**6.24%**
259%	**$ 2,204.09**	**$ 50.00**	**2.27%**	**$ 56.66**	**2.57%**	**$ 106.66**	**4.84%**
260%	**$ 2,212.60**	**$ 50.00**	**2.26%**	**$ 56.66**	**2.56%**	**$ 106.66**	**4.82%**
300%	**$ 2,553.00**	**$ 50.00**	**1.96%**	**$ 56.66**	**2.22%**	**$ 106.66**	**4.18%**
301%	**$ 2,561.51**	**$ 100.00**	**3.90%**	**$ 56.66**	**2.21%**	**$ 156.66**	**6.12%**
400%	$ 3,404.00	$ 100.00	2.94%	$ 56.66	1.66%	$ 156.66	4.60%
401%	$ 3,412.51	$ 150.00	4.40%	$ 56.66	1.66%	$ 206.66	6.06%
500%	$ 4,255.00	$ 150.00	3.53%	$ 56.66	1.33%	$ 206.66	4.86%

III. Employer fee sparks legal controversy

While HSF has been praised by many unions, including the San Francisco Council, Service Employees International Union Local 1021, SEIU United Health Care Worker's West and United Here! Local 2, as well as the uninsured beneficiaries, the plan faced a legal challenge when the mandatory employer subsidy component was the focus of a lawsuit filed by the Golden Gate Restaurant Associate (GGRA).

The Golden Gate Restaurant Associate (GGRA)[14], a non-profit trade association of 900 members, challenged the legality of the HSF's employer spending mandate, saying it conflicted with the Federal Employer Retirement Income Security Act of 1974 (ERISA).

[14] For more information, visit: http://www.ggra.org

According to ERISA, preemption as interpreted by the U.S. Supreme Court and lower courts, state and local governments cannot require employers to offer health insurance to their employees. While GGRA said it supported the idea of tackling the problem of uninsured in the city, the organization argued that HSF's employer spending mandate "eliminates employers' flexibility to create benefits plans tailored to their own employees, operations and budgets".[15] As a result, employers could not choose lower-cost coverage to extend benefits to more employees or negotiate lower rates of health care coverage for a greater set of benefits.

According to Kevin Westlye, GGRA's executive director, the mandatory contribution fee would put some restaurants out of business. He also argued that HSF did not have any element of cost containment, thus it is not a true reform.[16]

Before filling the lawsuit, GGRA proposed alternatives to fund HSF which include:

- (1) A quarter cent increase in the local sales tax rate. However, state law requires local sales tax to be approved by the voters. If it is dedicated to a specific program, as with Healthy San Francisco, it would require a two-thirds vote, which is a steep hill to climb.

- (2) An increase in the annual business registration fee, which averages $350 per business in San Francisco. The city attorney's office determined that business license fees cannot legally be used for this purpose. San Mateo County came to the same conclusion in their research for an adult healthcare expansion. The GGRA was notified of this shortly after they proposed it.

- (3) An employer mandate in the current ordinance for business with 500 or more employees.

Any of these three sources would have raised at least $36 million and met the required business contribution to HSF. However, the negotiation failed, as Mayor Newsom wanted to implement HSF without raising taxes. In addition, none of these alternatives addressed the issue of crowd-out or created a level playing field between employers. A business license fee, if found legal, would have placed the same burden on those employers who currently spend significant funds on healthcare and those who do not. This was a major issue for labor unions, which placed a high premium on reducing any competitive advantage of firms that do not spend on health care. GGRA also tried another strategy to draft a ballot measure. This effort also failed since state law prohibits establishing a sale tax through a voter initiative.

On April 5, 2007, granted by the Federal Judge Jeffrey White, a group of labor unions, including the San Francisco Central Labor Council[17], the Service Employees International Union, Local 1021, SEIU United Healthcare Workers-West, and the United-Here! Local 2 intervened on behalf of the city to support HSF, defending the employer spending mandate.

In the "Intervenor-Defendants' reply in support of a motion for summary judgment,[18] they argued that the employer spending mandate would not require employers to modify ERISA plans. Instead, it would provide economic incentives that affect employer decisions about benefits. Employers could

[15] To obtain the "Case No. C 06-6997 JSW: Plaintiff' Golden Gate Restaurant Association's Reply Memorandum in Support of Motion for Summary Judgment." , visit: http://www.ggra.org/news.asp?newsid=16046&menuid=1248&submenuid=1794
[16] http://www.ggra.org/news.asp?menuid=1248&submenuid=1794&newsid=8706#
[17] Representing over 100,000 union members and their families, the San Francisco Labor Council worked with Supervisor Tom Ammiano on his universal healthcare legislation. http://www.sflaborcouncil.org/
[18] To obtain the "Case No. C 06-6997 JSW: Intervenor-defendants' Reply In support of Motion for Summary Judgment," visit: http://www.ggra.org/news.asp?menuid=1248&submenuid=&newsid=16046

either make payments for healthcare through ERISA plans or make a quarterly payment to the city. The latter would help employers reduce their health care cost because the majority of covered employers already spend more for health care than the threshold set by the Worker Health Care Security Ordinance. Moreover, complying with the employer spending mandate would reduce a substantial amount of administrative obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping records.

On December 26, 2007, U.S. District Judge Jeffrey White ruled against the employer spending mandate. The mandate would "interfere with employer autonomy over whether and how to provide employee health coverage, and (with) ensuring uniform national regulation of such coverage," thus violating the ERISA[19]. In response to the Judge's ruling, Major Newsom and City Attorneys sought an emergency stay of the Judge's decision from the Ninth U.S. Circuit Court of Appeals to allow the employer fee to take effect as scheduled. On January 9, 2008, the stay was granted by a three-judge panel of the Ninth U.S. Circuit Court of Appeals ruled in favor the city, reasoning that "the city will probably succeed in showing that San Francisco's ordinance is legal and not preempted by ERISA" and that "the ordinance will help to prevent human suffering and that the stay will serve the public interest." [20] The Bush administration and the U.S. Department of Labor backed GGRA in its appeals on April 17, 2008 at a federal appeals court[21]. The outcome of this case, which is still pending as of this writing, has great significance for other cities and states that are considering employer payments to help defray the cost of covering the uninsured.

IV. Lessons and implication from the San Francisco Experience

No one involved with HSF sees it as an alternative to state and federal reform. HSF is a successful first step toward providing health care for everyone and offers many valuable lessons for advocates and state and local officials in other areas. Key factors underlying the success of HSF include political leadership, a strong delivery system foundation on which to build, strong community support and the availability of supplemental state and federal funds.

1. Political leadership

In many ways, the greatest success of the effort was building the political will. Since the beginning, Supervisor Ammiano and Mayor Newsom played vital roles in this achievement. As a restaurant owner and a potential gubernatorial candidate with a national profile, the mayor in particular is an important spokesperson. He sends a signal that when combining political will with a realistic proposal, a committed and unified coalition, and policymakers that want to be constructive, achieving health reform is possible.

2. Strong foundation of delivery system

HSF is not an insurance program. It is an organized care delivery system based in a public hospital and a strong network of community clinics, supplemented by services from other providers. Services

[19]San Francisco Chronic (December 27, 2007), "Federal Judge Rules Against S.F. on Health Care Plan" written by Bob Egelko and Heather Knight. http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/12/27/BA5AU50F2.DTL&tsp=1
[20] Family USA (January, 2008), "Appeals Court Says San Francisco's Pay or Play Law Go into Effect." http://www.familiesusa.org/resources/state-information/expansions/san-francisco-employer.html.
[21] San Francisco Chronicle, April 17, 2008

are comprehensive, but only available within San Francisco. This model can be applied to other counties and cities if existing public and private providers can be organized into a coherent whole.

3. Strong support from labor unions and community organizations

Along with others who lead and participated in the Universal Healthcare Council, labor unions and community organizations played a central role to the success in keeping the issue alive and getting the ordinance crafted and passed. In addition, having all the stakeholders at the table (providers, insurers, business and labor) was vital to reaching an agreement with broad public support.

4. Available funds from city, state and federal sources to provide care for the uninsured

This model can be applied to other cities and counties if there are available funds to provide care for the uninsured in the form of federal Disproportional Share Hospital (DSH) Funds or other public resources. Beside the city's fund to care for the uninsured, as a universal health care model the program also receives certain state and federal revenues which are critical to maintain the sustainability of the program.

5. Don't write off local action

HSF illustrates that localities can make progress on covering the uninsured, even if statewide efforts confront setbacks. This is potentially important in many states where statewide coverage expansion efforts are not on the table. In addition to its potential replicability in other localities, HSF offers a microcosm of the ingredients for successful health reform at any level.

The Universal Healthcare Council

(Source: Ken Jacobs, UC Berkeley Center for Labor Research and Education)

The Universal Healthcare Council was made up of a broad mix of stakeholders including health care providers, foundations, labor, business and community organizations. The Council played an important role in building consensus to create a health access plan based in a network of public and non-profit providers financed by the public, individuals and employers.

Co-Chairs
Lloyd Dean, CEO, Catholic Health Care West
Sandra Hernández, MD, CEO San Francisco Foundation

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

Chronology of Healthy San Francisco

(Source: Jessica Rothhaar, Health Access)

November 2004: Prop 72 fails statewide but gets 70% of the vote in San Francisco

Dec 2004 – Feb 2005: With strong support from labor unions and community organizations, Supervisor Ammiano moved forward with a requirement for employers to contribute to the city's cost for providing health care to workers. First draft of Worker Health Care Security Ordinance was prepared.

Key players:

- Tim Paulson & Pilar Schiavo at the Labor Council;
- Bruce Livingston & David Grant at Senior Action Network;
- Roma Guy of Health Access, California Women's Agenda and the SF Health Commission;
- Beth Capell, SEIU & Health Access;
- Ken Jacobs, UC Berkeley Labor Center
- Ian Lewis (UNITE HERE Local 2)
- Paul Kumar (SEIU UHW)

March - April 2005: At Ammiano's request, the Office of Legislative Analyst produced analysis of options for an employer fee in San Francisco

Mid- 2005: The Mayor appointed the Blue Ribbon commission "to make policy recommendations to the Board regarding imposing a fee to fund enforcement of the ordinance… [and the]… feasibility of creating an insurance pool for uninsured workers…"

December 2005: Public campaign to pass the "Workers Health Care Security Ordinance" begins in earnest. Endorsements sought.

February 2006: Mayor Gavin Newsom announced the formation of the Universal Healthcare Council and brought forward a proposal from Mitch Katz, Director of Public Health, to reorganize the public health delivery system and create a citywide health access plan.

February 1, 2006: Board of Supervisors hearing on the Worker Health Security Ordinance: coalition has great community representation, so does the GGRA.

February 14, 2006: Senior Action Network sent a memo to UHC members explaining that the defined benefit plan they have developedI was part of an existing effort to pass the Worker Health Security Ordinance.

May 18, 2006: Women's Lobby Day at the Board of Supervisors: participants won new commitments from Bevan Dufty and Gerardo Sandoval, giving them a veto-proof majority.

May 18 - August 7: After Supervisor Ammiano and key players negotiated with Mayor Newsom, he informed the UHC on the possibility of a mandatory employer contribution requirement to fund the Defined Benefit plan.

Aug 7 2006: Mayor Newsom signed the ordinance.

April 2007: Healthy San Francisco was introduced in tandem with the HCSO.

July 1, 2007: Health San Francisco started its first phrase.

About Community Catalyst

Community Catalyst is a national non-profit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society. *www.communitycatalyst.org.*

