



Office of Economic Analysis

Economic Impact Report

Of the Proposed

Worker Health Care Security Ordinance

File No. 051919

File Description:

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

Proposed Ordinance Summary:

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

June 23, 2006

Executive Summary

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

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

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

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

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

Risk Factor Schedule

Risks	Possible mitigating actions by local governments
<p>Employers operate in a highly competitive environment and must continually adjust their hiring decisions based on market wage and benefit trends. To the degree businesses can pass through labor cost increases onto consumers in the form of higher prices for goods and services, they may be able to absorb this mandate. However, many businesses operate with limited profit margins, so some business closures are likely.</p>	<ul style="list-style-type: none"> • Consideration of a lower mandated spending minimum, or a longer transition time, for smaller companies as well as companies that have significant number of temporary staff and less profitable industries may help mitigate the risk of smaller company closures and job losses in the short-term.
<p>Having one jurisdiction with a mandate as compared to a region, state or nation, can put that jurisdiction at greater risk for jobs loss. Health benefit mandates increase the cost of doing business in San Francisco. This increases the risk that employers will leave or not locate in our jurisdiction if other jurisdictions lack those same mandates. This risk could grow as the cost of the mandate grows over time.</p>	<ul style="list-style-type: none"> • Encourage a legal mandate at the State and Federal level for coverage minimums that require all employers to provide at least a base level of health benefits, such as this proposed mandate and/or support of broader mandates at the State level—for example, California SB. 840. • Structure the health care expenditure mandate to an index other than the City's 10-County Survey Rate. Other factors could be the Consumer Price Index (CPI) or a regional Labor Cost Index.
<p>Proposed ordinance does not differentiate residency, benefiting both non-resident and resident uninsured employees at the expense of San Francisco-based businesses and government. This could have the effect of San Francisco subsidizing neighboring jurisdictions' public health needs.</p> <p>That being said, it may also attract more employees to seek work in the City putting downward pressure on wages.</p>	<ul style="list-style-type: none"> • Increasing health benefits for non-resident employees helps neighboring counties' public health safety nets at the expense of San Francisco employers. If funding were to instead accrue to the San Francisco public health safety net, a direct alignment between benefits and costs to San Francisco stakeholders would occur.
<p>Since a number of smaller businesses disproportionately have more part-time staff, more firms may be impacted with increased costs (administrative and mandate) than the establishments survey data suggests.</p>	<ul style="list-style-type: none"> • Consideration of a longer transition time, for smaller companies that have significant numbers of part-time staff may help mitigate these risks in the short-term.
<p>The proposed legislation provides a great deal of potential local remedy for what is a complex national and statewide problem; however, at the same time a number of unknown variables exist.</p>	<ul style="list-style-type: none"> • Given the magnitude of this undertaking and the significant number of unknowns involved, a gradual or phased approach may be warranted.

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

Economic Effects	If this ordinance passes	Without ordinance
City Economy	<p>Nearly Neutral Impact:</p> <ul style="list-style-type: none"> The estimated incremental cost of this ordinance on San Francisco employers ranges between \$30.9 M and \$49.0 M in the first year of implementation, which by economy-wide standards is small as most employers with more than 19 employees already provide coverage. Projected 140 to 250 new health care jobs assuming service is provided in San Francisco. Projected 60 to 590 jobs losses, predominantly from staff cuts or business closures at employers with 20 to 49 employees. Reductions will likely impact lower-wage employees disproportionately. 	<ul style="list-style-type: none"> The Bay Area Economic Forum, using data from the 2003 California Health Interview Survey (CHIS) estimated that, in 2003, <u>148,000</u> San Franciscans were uninsured, at some point over a year's time. The San Francisco Mayor's Universal Healthcare Council, 2006, estimated that on average <u>82,000</u> persons were without coverage per year.
Covered Employers NOT Currently Providing Health Care Benefits at Mandated Levels	<p>Moderate Adverse Impact:</p> <ul style="list-style-type: none"> Employers with more than 19 but less than 100 employees shall provide health care expenditures of no less than \$2,194 annually per covered full-time employee² (Estimated to pay approximately \$29.3 M to \$31.0 M, in first year). Employers with 100 or more employees shall provide health care expenditures of no less than \$3,291 annually per covered full-time employee³ (Estimated to pay approximately \$1.6 M to \$18.0 M in first year). According to the California Health Care Foundation 2005 Survey, the average employer contribution toward employee health care in California is \$3,361 annually – an amount that exceeds both proposed mandate levels currently. Over time, mandated health care expenditure growth is likely to continue exceeding the average rate of inflation – historically the 10-County Rate has risen on average 7.4% to 8.1% per year over the past 10-20 years, compared to an average of 2.5% for overall inflation for the San Francisco Bay Area. Increase in administrative costs as they must maintain health expense records and report annually to the Office of Labor Standards Enforcement (OLSE) to demonstrate compliance. 	<ul style="list-style-type: none"> San Francisco's daytime population is significantly greater than our resident population due largely to non-resident workers commuting into the city each day. Some of these workers are uninsured. Using Metropolitan Transportation Commission (MTC) commute pattern estimates, total uninsured resident (employed and unemployed) as well as non-resident (employed) persons may total as much as 189,000 over the course of the year.¹ Employers have been shifting health benefit costs onto employees through increased deductibles, higher co-payments and co-insurance.

¹ This count includes unemployed residents and employees not covered by the plan as they may be self-employed, or employed by businesses not covered by this ordinance's definition—i.e., companies with fewer than 20 employees.

² Calculation takes 50% of the 10-County Survey Rate x 172 hours per month x 12 months per year x # of full-time equivalent employees per year, in verifiable health care expenses on behalf of his/her employees.

³ Calculation takes 75% of the 10-County Survey Rate x 172 hours per month x 12 months per year x # of full-time equivalent employees per year, in verifiable health care expenses on behalf of his/her employees.

Economic Effects	If this ordinance passes
<p>Covered Employers ALREADY Providing Health Care Benefits Above Mandated Levels</p>	<p>Neutral Impact initially to Moderately Adverse over time.</p> <ul style="list-style-type: none"> • No short-term significant impact when employers are spending \$2,194 annually per employee, for firms with more than 19 but less than 100 employees, or \$3,291 annually per employee, for firms with 100 or more employees. • Will see some increase in administrative costs as they must maintain health expense records and report annually to the Office of Labor Standards Enforcement (OLSE) to demonstrate compliance. • Potential adverse impact to employers over time if the rate of growth in the City's Annual 10-County Health Survey limits the flexibility that employers have in shifting health costs onto employees through required higher deductibles, co-insurance and co-payments.
<p>Covered Employees with Health Care Benefits Less than Mandated Levels</p>	<p>Moderate Favorable Impact:</p> <ul style="list-style-type: none"> • Projected to benefit an estimated 14,070 to 19,570 covered employees currently uninsured and employed in San Francisco, regardless of residency. • Incremental benefit per employee (and cost to employer) represents 15.9% to 3.5% of overall total wage costs for firms not currently providing health care benefits, assuming an average wage range of \$10.00 to \$30.00 per hour for qualified employees⁴. • Depending on the average wage of impacted businesses, we project an estimated loss of 60 to 590 full-time jobs.
<p>Covered Employees with Health Care Benefits Above Mandated Levels</p>	<p>Neutral to Moderately Favorable Over Time:</p> <ul style="list-style-type: none"> • Employees expected to continue to benefit, though employers will now have a minimum expenditure level that they must provide. This may provide some protection from increased cost shifting, but will also likely otherwise decrease wage growth over time.
<p>City & County Government</p>	<p>Neutral to Moderate Favorable Impact:</p> <ul style="list-style-type: none"> • Reportedly, the ordinance may cost at least \$0.48 million in additional costs at the City, primarily at the Office of Labor Standards Enforcement plus some potentially minor amount of additional operating costs to Controller's Office for appeals adjudication.⁵ • Payroll Tax revenues may be impacted depending on the change in jobs. • Non-profit contracting costs may also be impacted depending on amount of City funding provided to non-profits to cover incremental costs. • Projected numbers of covered employees who benefit are 14,070 to 19,570 compared to the projected job losses of 60 to 590 (mainly smaller employers) with potential offsetting new health care jobs of 150 to 240. • Increased coverage may relieve some of the burden on the health safety net provided by the Public Health Department; however, our assumption is that these potential savings would be reprogrammed to provide further unmet public health needs.

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

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

SUMMARY OF COSTS AND BENEFITS

City Economy

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

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

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

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

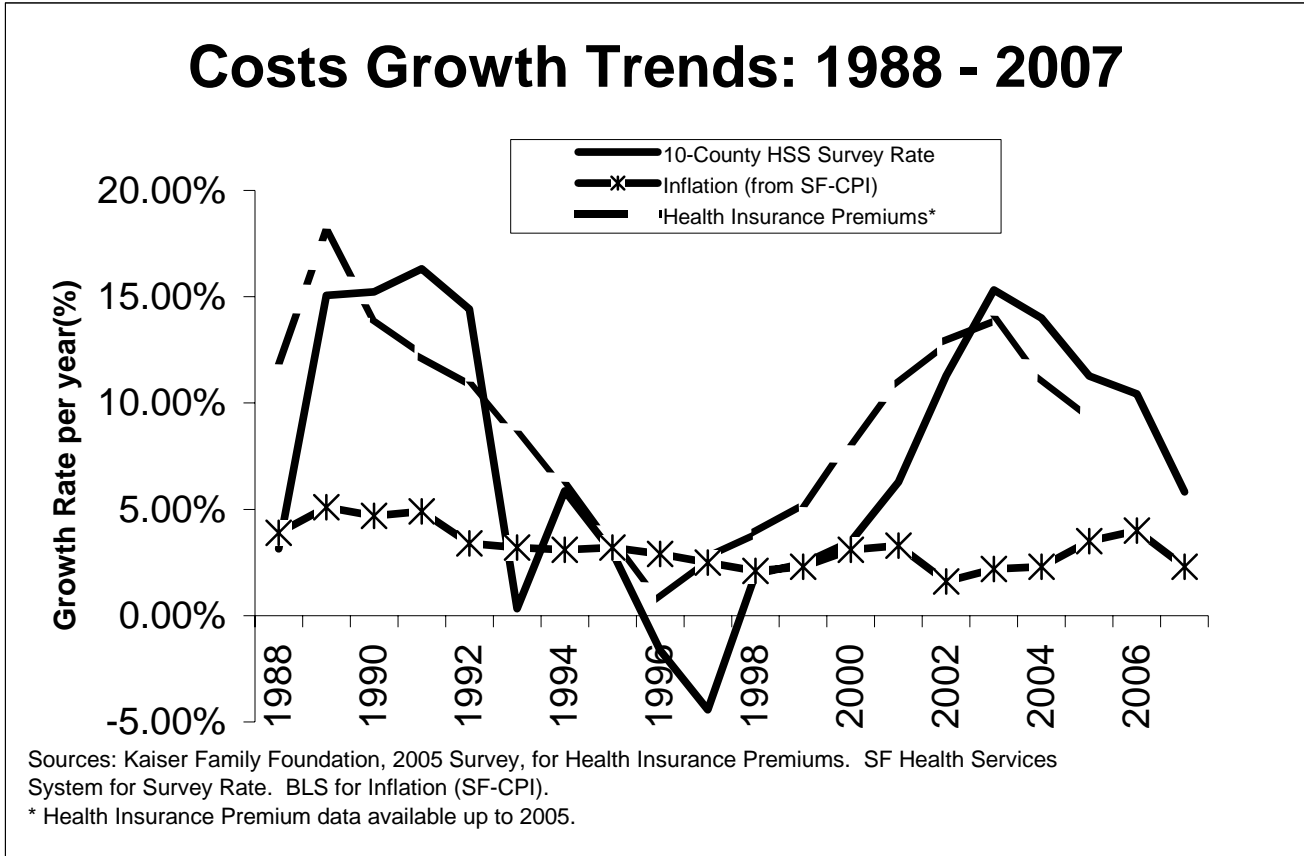
Another assumption we made is that currently, employers offering health benefits are generally spending at least as much as this ordinance mandates, which for FY 2006-07 is either \$2,194 or \$3,291 annually depending on the size of the employer. While this appears to be consistent with the 2005 Employer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

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

⁶ For example, locally owned and typically owner operated restaurants, business services and retail establishments.

⁷ The 2005 CHCF Survey finds that only 35% of low-wage paying firms, and 33% of businesses with many part-time employees offer health care expense coverage.

Figure 1



Employers Covered Under this Proposed Ordinance

Table 1 on the follow page illustrates Health Care Benefits by Business Size in San Francisco. Consistent with studies of Bay Area Employer Provided Healthcare⁸, most workers who are projected to be positively impacted by this legislation work in smaller businesses — businesses between 20 to 49 employees.

⁸ See referenced studies in the bibliography by the Bay Area Economic Forum, and by UC Berkeley with Working Partnerships USA.

Table 1. Health Care Benefits by Business Size

Impact of Ordinance	Number of Businesses by Size							
	Total	20-49	50-99	100-249	250-499	500-999	1000 or more	
Total Businesses ¹	42,864	2,594	890	494	144	58	34	
Covered Employers	4,214	2,594	890	494	144	58	34	
Jobs	530,452	89,493	66,305	86,203	53,928	43,471	63,654	
% of Employers Offering Health Coverage	UC Berkeley Study ²		87%	95%	97%	97%	99%	99%
	California Health Care Foundation Survey, 2005 ³		88%	95%	98%	98%	98%	98%
	Kaiser Family Foundation National Survey, 2005 ⁴		74%	87%	92%	92%	99%	99%
Businesses Impacted	UC Berkeley Study	402	337	45	15	4	1	0
	California Health Care Foundation Survey 2005	371	311	45	10	3	1	1
Jobs Impacted	UC Berkeley Study	14,070	11,795	1,575	525	140	35	0
	California Health Care Foundation Survey 2005	19,572	10,730	3,353	1,745	1,124	750	1,872
Employer Costs in Millions	UC Berkeley Study	\$ 30.87	\$ 25.88	\$ 3.46	\$ 1.15	\$ 0.31	\$ 0.08	\$ 0.00
	(%)	100.0%	83.8%	11.2%	3.7%	1.0%	0.2%	0.0%
% Burden of Cost	California Health Care Foundation Survey 2005	\$ 48.96	\$ 23.54	\$ 7.36	\$ 5.74	\$ 3.70	\$ 2.47	\$ 6.16
	(%)	100.0%	48.1%	15.0%	11.7%	7.6%	5.0%	12.6%

1. Data Source: California EDD, Second Quarter 2005 Estimate.

2. UCBLC Study, Refers to UC Berkeley Labor Center and Working Partnerships USA Study, Declining Job-Based Health Coverage in the United States and California: A Crisis for Working Families, by Arindrajit Dube and Ken Jacobs.

3. Source of estimated %: Bay Area Economic Forum Study, January 2006, and California Health Care Foundation Survey, 2005. State based survey.

4. Source of estimated %: Kaiser Family Foundation Survey, 2005. National Based Survey.

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

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

Table 2. Firms with Lower Average Wages Impacted More

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

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

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

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

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

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

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

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

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

Employees Covered Under this Proposed Ordinance

Employees who currently do not receive health benefits will benefit greatly from this ordinance in the immediate future. An estimated 14,070 to 19,570 employees will be positively impacted. The proposed ordinance results in additional health benefit expenses on behalf of employees that amount to 3.5 to 15.9 percent increases in total compensation, depending on the average wage of the firm. Based upon our review of labor economic research, increased wage costs result in reductions to labor of 0.1 to 0.3 percent for each 1.0 percent increase in total compensation costs. Thus, the positive impacts on employees by this ordinance will be partially offset by estimated job losses of 60 to 570.⁹ While job losses are projected to occur primarily among smaller employers, as they disproportionately do not currently provide health benefits, some job gains are also expected in the health care industry. Depending on the rate of incremental health care spending that occurs within San Francisco, job gains in health care could range from 150 to 240.

City & County Government

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

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

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

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

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

Conclusion

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

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

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

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

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

The Health Insurance Policy Board:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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