

icaid and SCHIP but will not turn the patchwork into a true system.

So, though deeply dysfunctional by most standards, the U.S. health care system remains disturbingly stable. That no one really likes it does not translate into the inevitability of real change. Because the system is unlikely to collapse from within, reformers' best hopes lie with shifts in public sentiment and the election of activist and reform-minded political leaders. Such shifts can happen, as they did with lasting consequences in 1932 and 1964. But big bangs do not guarantee com-

prehensive health care reforms. Franklin Roosevelt declined to include national health insurance in his package of New Deal programs. Lyndon Johnson won enactment of Medicare and Medicaid but declined to fight for universal coverage. Since 1968, U.S. social politics have proceeded largely to the right of center, and the health care reform ideas whose time seemed to have come in 1993 crashed dramatically.

Underestimating the system's resilience risks leading reform astray yet again, but what exactly should be done is far from clear.

No one knows how to infuse moral urgency into the push for universal coverage, make the system's medical style markedly less expensive, and thrust reform to the top of the agenda for powerful interest groups. Careful reconnoitering of historical terrain yields no formulas for success but may at least reduce the prospects of *déjà vu*.

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Golden Gate to Health Care for All? San Francisco's New Universal-Access Program

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Impatient with the lack of progress at federal and state levels in reducing the number of uninsured Americans, many counties across the United States are seeking their own solutions to the health care crisis. Unfortunately, local efforts to achieve universal coverage often encounter substantial obstacles, including the high cost of insurance plans, the loss of federal and state revenues that benefit the uninsured, and limited authority to mandate insurance coverage.

To broaden access while avoiding these problems, the government of the City and County of San Francisco launched Healthy San Francisco (HSF) in April 2007. Building on the success of an earlier effort to provide health insurance for nearly all the city's children, HSF is a novel initiative designed to make comprehensive health care available to San Francisco's 73,000 uninsured residents

(13% of adults under the age of 65 years).¹

Currently in the form of a phased start-up, HSF is not an insurance program but rather a restructuring of the county's health care safety net. Administered by the San Francisco Department of Health, where I am director of health, HSF's universal-access model features key elements of managed care, such as "medical homes," defined participation and point-of-service fees, and customer service. It provides inpatient and outpatient care, tertiary subspecialty care, prescription coverage, laboratory services, durable medical equipment coverage, and treatment for mental illnesses and substance abuse. (Cosmetic procedures, dental services, fertility treatments, organ transplantation, vision care, and long-term care are excluded.)

All uninsured residents between 18 and 65 years of age are eligible

to enroll in HSF regardless of income, employment status, immigration status, or preexisting conditions. During an online application process, clients' eligibility for federal and state programs such as Medicaid is first determined. Those who are eligible can enroll in the appropriate program; those who are not are enrolled in HSF and choose a primary care home from among 14 county and 8 private nonprofit clinics. (As enrollment grows, we hope to broaden the network of providers.) Participants are given an identification card, a handbook explaining how to obtain services, a list of standard point-of-service charges, and access to multilingual customer assistance. Participation is free for residents whose incomes fall below the federal poverty level. Others pay quarterly participation and point-of-service fees (see Tables 1 and 2), with total fees for those at or below 500% of the

Table 1. Healthy San Francisco Quarterly Participant Fees.*

Family Income as a Percentage of FPL	Standard Fee	Employee Discounted Fee \$
0–100%	0	0
101–200%	60	0
201–300%	150	0
301–400%	300	75
401–500%	450	113
≥501%	675	169

* The employee discounted fee is for persons whose employer contributes toward the cost of enrollment. FPL denotes federal poverty level.

federal poverty level amounting to less than 5% of family income to ensure affordability.²

HSF provides enrollees with many of the benefits of managed care. Assigning patients to a medical home and primary care provider improves treatment outcomes and reduces the likelihood of costly emergency room visits and duplication of care.³ The charging of small fees is expected to attract some people who have refrained from seeking care because they considered it unaffordable and refused to accept “charity care.” And the provision of continuous coverage that is not tied to employment gives San Franciscans security even if they change jobs or become unemployed.

There are some disadvantages of a non-insurance-based system. Only services provided at a participant’s primary care home and associated hospital are covered (right now, only the county hospital is participating). Emergency care obtained at noncontracted hospitals is not covered. Although emergency care is guaranteed by the federal Emergency Medical Treatment and Active Labor Act, the cost is billable to the patient and can result in a serious financial burden. In addition, unlike in-

surance, HSF will not pay for care received outside San Francisco, and enrollees will lose all benefits if they move to another city.

Despite these drawbacks, HSF’s universal-access model is a logical option for San Francisco from a cost and financing standpoint. The direct costs of the program are estimated at \$198 per person per month — substantially less than the cost of commercial health insurance (though this estimate is admittedly based on the somewhat unfair assumption that there will be no adverse selection — that people with greater health care needs will not be more motivated to join than those with fewer needs). Administrative expenses are expected to be lower than is usual for a health plan — 5% versus 9 to 14% — since HSF does not provide certain services that insurers do (for instance, the program will not be adjudicating out-of-network claims). Assuming a 7% inflation rate for the first 2 years of gradual enrollment, the overall cost of HSF in year 3, when enrollment is expected to be 60,000 (82% of the uninsured), will be approximately \$171 million.

There are other cost advantages to a universal-access model, including a decreased risk of “crowd-out,” which occurs when insured individuals or businesses drop their coverage to take advantage of a subsidized plan, a practice that can drain subsidy dollars and lead to insufficient program funding. The fact that HSF does not pay claims originating outside the medical home reduces the likelihood of crowd-out. Unlike insurance, a universal-access model allows the county to continue receiving certain federal and state revenues, which are critical for maintaining HSF’s fiscal viability. In addition, HSF enrollees will remain qualified for certain federal

and state benefits (e.g., the AIDS Drug Assistance Program) that are unavailable to insured patients.

Financing for HSF is slated to come primarily from existing county funds for the care of the uninsured, which in 2007 totaled approximately \$123 million. An annual \$20 million is expected from existing federal and state health programs, and a 3-year health care expansion award from the state will add \$24 million per year to the budget. It is hoped that since the source of these funds is California’s ongoing hospital waiver, funded through the Centers for Medicare and Medicaid Services, the revenue will be maintained after year 3.

In addition, a health care spending requirement for employers was enacted under the same ordinance as HSF.⁴ Employers with 100 or more employees would be required to spend \$1.76 per work hour per employee on health benefits; those with 20 to 99 employees would have to spend \$1.17 per hour. Employers could use this money to provide health insurance, create health savings accounts, pay health care claims, or contribute toward employees’ participation in HSF, thereby qualifying employees for free or discounted coverage (see Table 1).

The employer spending requirement was legally challenged by a local restaurant association. A U.S. district court ruled in favor of the association, stating that the goals of the program were “laudable” but that the spending mandate was preempted by the Employee Retirement Income Security Act (ERISA), enacted by Congress in 1974. The act was designed to protect employers from having to tailor their benefit plans to a variety of local regulations. However, the city appealed the case to the U.S. Court of Appeals for the Ninth

Table 2. Healthy San Francisco Point-of-Service Fees.*

Service	Family Income ≤100% of FPL	Family Income 101–500% of FPL	Family Income >500% of FPL
		\$	
Outpatient primary care	0	10	20
Urgent care	0	20	50
Radiology or physical or occupational therapy	0	20	50
Specialty care	0	20	50
Pharmacy use	0	5 or 25	25 or 50
Emergency department care	25	50	100
Same-day surgery	0	100	200
Hospitalization	0	200/admission	350/admission

* For pharmacy use, preferred drugs have lower point-of-service fees than nonpreferred drugs. The emergency department fee is charged only if the triage nurse determines the patient does not require immediate attention. Fees for behavioral health care are determined by the Uniform Method of Determining Ability to Pay system developed by the State of California for all counties providing mental health services. FPL denotes federal poverty level.

Circuit and asked the court to grant a stay of the district court decision. The Court of Appeals granted the stay, noting that the city has a “strong likelihood” of success in arguing that the employer spending mandate is not preempted by ERISA. Therefore, the spending mandate is in effect pending the appeal of the case.

The HSF model is most applicable to counties with multiple safety-net providers. Systematiz-

ing the services that county and community clinics, private doctors, and hospitals provide to the uninsured will result in improved care and better data for health care planning. Our experience suggests that, even in counties with a sole charity care provider, offering enrollment identification cards and clear, up-front cost information may comfort people who would otherwise worry about paying for care. In addition, having partici-

pants pay prospectively encourages them to seek preventive care.

With about 7400 people enrolled in HSF as of December 2007, it is still too early to tell how successful the program will be; nevertheless, we hope it will inspire more energetic efforts at the state and federal levels. With an estimated 47 million uninsured people in the United States, and overwhelming evidence that the uninsured have less access to care and poorer health outcomes than the insured, it is critical that we take action now.

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3. Grumbach K, Bodenheimer T. A primary care home for Americans: putting the house in order. *JAMA* 2002;288:889-93.
4. Health Care Security Ordinance: San Francisco Administrative Code, Chapter 14. (Accessed January 3, 2008, at <http://www.municode.com/Resources/gateway.asp?pid=14131&sid=5>.)

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Perspective

ROUNDTABLE

Physicians and Execution

On January 7, 2008, the U.S. Supreme Court heard oral arguments in *Baze v. Rees*, which turns on the question of whether the three-drug protocol used to carry out the death penalty by lethal injection causes avoidable pain and suffering, in violation of the Constitutional ban on cruel and unusual punishment. On January 14, the *Journal* hosted a roundtable discussion of the case, the protocol, and the involvement of health care professionals in lethal injection. Moderator Atul Gawande, associate professor of surgery at Harvard Medical School, was joined by Deborah Denno, professor of law at Fordham University; Robert Truog, professor of medical ethics, anesthesiology, and pediatrics at Harvard Medical School; and David Waisel, associate professor of anesthesia at Harvard Medical School. Watch the video of the roundtable discussion online at www.nejm.org.

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