

Health Care Accountability Ordinance

Minimum Standards Report

October 18th, 2016



San Francisco Department of Public Health
Office of Policy & Planning

I: The Health Care Accountability Ordinance

The Health Care Accountability Ordinance (HCAO) represents one of San Francisco's early pioneering efforts to reduce the number of uninsured in San Francisco. Grown out of the Living Wage movement and the Minimum Compensation Ordinance (MCO), the HCAO went into effect on July 1, 2001. It requires that employers doing business (through contract or lease) with the City either offer health insurance coverage that meets a set of Minimum Standards to their employees who are working on a City contract or on property leased from the City, or pay a fee to the Department of Public Health (DPH) to offset costs of health care provided to the uninsured.

The Office of Labor Standards and Enforcement (OLSE) acts as the regulatory body and the primary enforcement body for the HCAO. OLSE and DPH work closely together to ensure proper compliance among contractors and lessees. Not all contractors or leaseholders are subject to the HCAO, and when they meet one or more of the criteria, the contractor or leaseholder may obtain an exemption or waiver, granted through OLSE. Some of the most common reasons that an employer would not be subject to the HCAO include:

- The business employs too few workers: 20 or fewer (for profit); 50 or fewer (non-profit).
- The contract amount is too low: less than \$25,000 (for-profit) or \$50,000 (non-profit).
- The contractor is a public entity (e.g., UCSF).
- The contract duration is for less than one year.
- The agreement involves special funds, specifically programs funded through other sources than CCSF's General Fund, such as grant funds.

Employers that do not offer a health insurance plan that complies with the Minimum Standards pay an hourly fee directly to DPH on a monthly basis. For FY16-17, the fee is \$4.65 per hour worked per employee up to \$186 per week for each employee.¹

II: The HCAO Minimum Standards Review Process

The Health Commission has the sole authority to set the Minimum Standards. The last revision occurred in 2014, and they went into effect on January 1, 2015. Since 2004, it has been DPH's practice to convene a

"The Health Commission shall review such standards at least once every two years to ensure that the standards stay current with State and Federal regulations and existing health benefits practices."

Section 12Q.3.(a)(1):

workgroup of stakeholders that includes representatives from non-profit and for-profit employers, labor advocates, health insurance brokers, health plans, and City departments to contribute their expertise and experiences to this process.

The Minimum Standards must be workable for a full two years. It is common for health insurers to modify plan design from year-to-year, sometimes significantly. The Minimum Standards must take into consideration not just the current trends, but what is likely to happen in the future. With this in mind, Workgroup members sought to develop a set of recommendations to revise the Minimum Standards that would provide an array of health insurance options for employers, retain the comprehensive benefit package for employees, and consider affordability for employers and employees. It is crucial that the Minimum Standards carefully balance the needs of the employers and the employees. If the premium costs to the employer are set too high, the employer is incentivized to drop coverage and pay the fee instead. If the costs for the plan's services are too high, the employee may delay or avoid health services.

A. The HCAO Workgroup

Starting on September 8th, 2016, the Workgroup met three times, with the last meeting on October 5th. Patrick Chang, with the Office of Policy & Planning (OPP), chaired the committee, and Mavis Asiedu-Frimpong from OPP provided additional support. Many of this year's Workgroup members participated in previous years, with some going back as far as the drafting of the original Ordinance. Others were new to the process, but their organizations were engaged in the previous workgroups. Participants included representatives from both for-profit businesses and non-profit organizations, a practice that is consistent with recommendations by the Health Commission in 2008. A list of the Workgroup's membership can be found in Attachment B. All members of the Workgroup approved the recommendations in this report.

¹ Office of Labor & Standards Enforcement (2016). Health Care Accountability Ordinance.

Lynn Jones, NFP Insurance Services Inc., and Larry Loo, Chinese Community Health Plan, were of great assistance to the Workgroup with their expertise on the health insurance marketplace. They provided information and small group insurance data that was crucial to the process and provided insight on the vast legislative changes, health plan dynamics, and trends in the marketplace.

B. Health Care Trends

Despite health reform stabilizing costs compared to previous years, the costs of health insurance are rising rapidly for all participants in the health care system. Consider the following findings:

- Overall, patient cost-sharing rose by 77%, from an average of \$422 in 2004 to \$747 in 2014. During that period, average payments by health plans rose 58%, from \$2,748 to \$4,354. This reflects a modest decline in the average generosity of insurance.²
- Premiums for health coverage on Covered California, CA’s health insurance exchange, will rise by an average of 13.2% in 2017 – more than three times the increase of the last two years.³
- According to Covered California’s latest preliminary rates, SF residents will experience an average increase of 14.8%, higher than the statewide average.³

Employees are being asked to pay more for their coverage in the form of deductibles (an amount that must be paid by the enrollee before all or most services are covered by the health plan), coinsurance (a percentage of the overall charge paid by the enrollee), and higher copayments (a fixed dollar amount paid by the enrollee to access a service). High deductible health plans (HDHP) are often combined with a health savings account (HSA) or health reimbursement

arrangement (HRA), and are becoming more commonplace.

Since the ACA’s implementation, health plan variability has significantly narrowed due to the use of actuarial values for metal tier levels. For example, a silver-level plan is generally designed for the health plan to cover 70 percent of all costs – though that calculation fluctuates when a consumer requires inpatient hospital services. Nevertheless, findings show that there are continued concerns about a lack of affordability impacting consumer choices in seeking health care services. So, it is more important than ever to ensure that the HCAO Minimum Standards are flexible enough to withstand the rapid changes in the health insurance market, while protecting employees and allowing reasonable options for employers (lest they drop coverage altogether).

C. Health Plan Review

The Workgroup evaluated information from 111 small group health plans to make its decisions. California defines a small business as having 100 or fewer employees for the purposes of health insurance. DPH used this part of the health insurance market because small businesses have significantly less flexibility in choosing insurance products, while larger businesses possess greater leverage to negotiate their plans. Therefore, it is crucial that the HCAO Minimum Standards are set so that there are a number of plan options available in the small business market. In addition, the Workgroup used the plans as a proxy to extrapolate what is normal in the overall health insurance market. The table below summarizes the plans the Workgroup reviewed:

2016 Workgroup Small Group Health Plan Review

Carrier	Bronze	Silver	Gold	Platinum	Total
Aetna	5	5	7	3	20
Anthem Blue Cross	4	6	11	3	24
Blue Shield	4	4	6	5	19
Health Net	2	1	4	3	10
Kaiser	4	6	7	5	22
United Healthcare	3	4	5	4	16
Total	22	26	40	23	111

² The Kaiser Family Foundation (2016). Payments for cost sharing increasing rapidly over time

³ Covered California (2016). Covered California’s Health Insurance Companies and Plan Rates for 2017 (Preliminary Rates)

III: Minimum Standard Recommendations

In order to be compliant with the HCAO, a covered employer must offer the employee a plan that meets or exceeds each of the Minimum Standards. The Workgroup reviewed a range of 2016 small group plans across six carriers, and found only gold and platinum level plans on the marketplace are compliant with the current Minimum Standards. With interest in expanding the number of silver plans that employers could choose from while minimizing the negative impact of increasingly high deductibles on workers, the Workgroup analyzed 10 different variations on the standards against the small group plans.

Given this review and analysis, the Workgroup recommended:

- changes to five of the Minimum Standards;
- adding clarifying language that preventive and wellness services and pre/post-natal care are standardized by ACA rules at no charge; and
- adding clarifying language that coverage of services in standards 8 and 11-16 are standardized by ACA rules.

A side-by-side comparison of the current Standards and the Workgroup's recommendations is contained in Attachment A. The following section describes the recommendations and their rationale:

Minimum Standard 1, Premium Contribution: Employer pays 100%

Insurance premiums refer to the monthly or annual cost of maintain health insurance coverage. According to the California HealthCare Foundation, premiums for job-based family coverage rose by 169.7 percent between 2002 and 2012. This rate of increase is roughly five times the increase in overall inflation.⁴ Given that all types of health care costs are rising, the consensus recommendation is to retain the current Minimum Standard to preserve the intent of the HCAO and best ensure employees access to affordable health coverage.

Recommendation: Retain the current Minimum Standard.

Minimum Standard 2, Annual Out-of-Pocket Maximum: No higher than a \$6,350 maximum, including all types of employee cost sharing (deductible, copayments, coinsurance, etc.).

Nearly all health insurance plans set a specific Out-of-Pocket (OOP) maximum, which limits the insured's financial liability for the year. The amount an insured person pays during the year in deductibles, coinsurance, copayments, and other cost-sharing cannot exceed the OOP maximum. The ACA set the 2016 annual OOP maximum to \$6,850, and it is set to increase to \$7,150 for 2017.⁵

Virtually all 2016 silver and gold plans reviewed had an OOP max at or above \$6,000. Silver and gold Kaiser small group plans for 2017 set the limit at or above \$6,500. The consensus recommendation is to increase the maximum amount to \$6,850 in order to allow employers access to the greatest number of health plans. Moreover, this limit will provide workers some protection from increases in 2017 and 2018.

Recommended New Minimum Standard: Increase the OOP maximum to \$6,850, including all types of employee cost sharing (deductible, copayments, coinsurance, etc.).

Minimum Standard 3, Medical Services Deductible:

- **In-Network: No higher than a \$1,500 maximum. Employer may offer a plan with a higher deductible only if they combine it with a fully employer-funded health savings account or health reimbursement account for the amount exceeding \$1,500.**
- **Out-of-Network: Not specified.**

The medical deductible was the most debated standard for the Workgroup. Some Workgroup members strongly advocated to disallow a deductible altogether as they observed – since its introduction in 2010 – the deductible posed a substantial financial barrier for lower-income employees. Specifically, high deductibles expose the insured to higher OOP costs, and more vulnerable employees either opted out of insurance coverage or never used their benefits at all. The Workgroup also acknowledged that education on how to use coverage and standardized ACA benefits – such as free preventive care services – is necessary.

Opposition to an outright \$0 deductible was based on the corresponding premium costs for such a plan. Only

⁴California Health Care Foundation (2016). Health Care Costs 101: ACA Spurs Modest Growth

⁵Obamacare Facts (2016). Out-of-pocket Maximum Limits on Health Plans

some gold and platinum plans were structured in that way, and their premium costs were typically 30-50 percent greater than silver plans. Since employers would be paying the full premiums for single coverage, this alone would create an excessive burden – especially for non-profit organizations. Still, all members agreed any revisions to the Minimum Standards must preserve the spirit of the HCAO, which is to increase access to affordable health coverage for San Francisco workers.

The Workgroup reached consensus on allowing a \$2,000 deductible, but employers would cover 100 percent of the deductible with either a fully employer-funded HSA or HRA with first-dollar coverage. This way, employers would be able to choose from a wider range of plans with lower premium rates, and a high deductible will not deter employees from seeking out health care services. Leveraging a HSA or HRA will enable employers to continue deciding allowable expenses and possibly have unused funds revert back to their ownership.

Recommended New Minimum Standard: Increase the In-Network medical services deductible to \$2,000. The employer must cover 100 percent of the medical deductible and may do so with either a fully employer-funded HSA or HRA. The HSA or HRA must provide first dollar coverage.

Minimum Standard 4, Prescription Drug Deductible:

- **In-Network: No higher than a \$300 deductible.**
- **Out-of-Network: Not specified**

Just like a deductible for medical services, a prescription drug deductible is the amount a consumer must pay for covered prescription drugs before the insurance plan begins to pay. Prescription drug costs have been particularly high in recent years, driven in part by the high cost and demand for new high-cost specialty drugs. Costs for prescription drugs continue to increase and are anticipated to again outpace the costs for other medical services. Currently, outpatient prescription drugs account for 10 percent of total health expenditures in the US.

In response to this cost trend, beginning in 2016, Covered California health plans could charge no more than up to \$250 per month for one 30-day supply for silver, gold, and platinum plan members and no more than up to \$500 per 30-day supply for bronze plan

members. Now, the vast majority of silver and above health plans with a Rx deductible set it at \$250 annually.

The Workgroup came to consensus to reduce the prescription drug deductible to \$250 to align with the Covered California metal tier structure that sets the limit at \$250 for silver plans and above.

Recommended New Minimum Standard: Decrease the In-Network prescription drug deductible to \$250.

Minimum Standard 5, Prescription Drug Coverage: Plan must provide drug coverage, including coverage of brand-name drugs.

Formulary drugs are those included on the list of prescription drugs covered by a prescription drug plan. In 2015, 58 percent of covered employees in California and 81 percent nationally had three- or four-tier cost-sharing coverage for prescription drugs.⁶ Consumers with four-tier cost-sharing coverage are exposed to the greatest financial risk. The Workgroup came to consensus to retain the current Minimum Standard to ensure employees have some level of coverage for all tiers of prescription drugs.

Recommendation: Retain the current Minimum Standard.

Minimum Standard 6, Coinsurance Percentages:

- **In-Network: 80% / 20%**
- **Out-of-Network: 50% / 50%**

Coinsurance is the percentage of costs that consumers pay for a covered health care service after paying for the deductible. The use of metal tiers to standardize a plan's actuarial value essentially translates to health plans covering 60 percent of costs for bronze, 70 percent for silver, 80 percent for gold, and 90 percent for platinum. As a result, within each tier, a lower deductible will correspond with higher OOP costs in the form of coinsurance and copayments. The relationship is consistent across cost-sharing where a lower value for one relates to a higher value for another. Interestingly, coinsurance percentages appear to be more common for HMO type plans. Recently released Kaiser plans for 2017 show that both silver and gold plans include a range of 20 to 30 percent coinsurance rates.

⁶California Health Care Foundation (2016). California Employer Health Benefits: Workers Pay The Price

Taken with the recommendation for the employer to cover 100 percent of the medical deductible, the Workgroup came to consensus on increasing the coinsurance limit to allow employers access to a greater range of plans with lower premium rates.

Recommended New Minimum Standard: Increase the In-Network coinsurance percentage to 70 percent / 30 percent.

Minimum Standard 7, Copayment for Primary Care Provider Visits:

- **In-Network: \$30**
- **Out-of-Network: Not specified**

A copayment is a fixed amount the consumer pays for a covered health care service after paying the deductible. The majority of silver and above health plans the Workgroup reviewed require an office visit copayment of \$35 or above. Taken with the recommendation for the employer to cover 100 percent of the medical deductible, the Workgroup came to consensus on increasing the copayment limit to allow employers access to a greater range of plans with lower premium rates.

Recommended New Minimum Standard: Increase the In-Network copayment for primary care provider visits to \$45.

Minimum Standards 9 & 10

- **Preventive & Wellness Services**
- **Pre/Post-Natal Care**

In 2014, the Health Commission accepted the recommendation to align the Minimum Standards with the ACA's Essential Health Benefits (EHB) and Covered California's benchmark plan. Nevertheless, a lack of familiarity with these EHBs is still common among both employers and employees, and many insured are – anecdotally – not seeking out free preventive services with the coverage they do have. The Workgroup wholly agrees that education on EHBs and how to use health benefits is a needed dimension when enrolling staff in coverage. Members came to consensus on the benefit of including language to the standards indicating that preventive, wellness, and pre/post-natal care services are provided at no charge per ACA rules and regulations.

Recommended New Minimum Standard: Retain the current Minimum Standard, and include language stating that these services are standardized by ACA rules at no charge to the insured.

Minimum Standard 8, 11-16

- **Ambulatory Patient Services (Outpatient Care)**
- **Hospitalization**
- **Mental Health & Substance Use Disorder Services, including Behavioral Health**
- **Rehabilitative & Habilitative Services**
- **Laboratory Services**
- **Emergency Room Services & Ambulance**
- **Other Services**

In 2014, the Health Commission aligned these standards with the ACA's list of EHBs. The Workgroup came to consensus to include language that coverage for these services is standardized by the ACA to preempt employer and employee confusion on cost-sharing structures for these services.

Recommended New Minimum Standard: Retain the current Minimum Standard, and include language stating that coverage of these services are standardized by ACA rules. Moreover, clarify that cost-sharing for these services are to conform to the requirements above.

IV: Conclusion

DPH fully supports the HCAO and maintains its deep-rooted interest in seeing the Ordinance meet its objective of reducing the numbers of uninsured San Franciscans and enhancing the quality, stability, health, and productivity of the workforce on City contracts and leases. As ACA reforms mature, the health insurance marketplace continues to adjust for increasing costs by shifting a greater proportion of OOP expenses to the consumer in the form of deductibles, coinsurance, and copayments. Due to across-the-board increases in health care costs, the volatile political environment, and the added unpredictability of an election year, there was not wide interest in syncing any Minimum Standard to a Covered California or ACA benchmark.

The HCAO Workgroup considered numerous options for change, and these recommendations represent the full consensus of its members. This solution takes the needs of employers and employees into consideration. In reviewing 111 small business plans available on the small group insurance market, only 30 percent are compliant with the current standards. The recommendations noted in this report increase this to 52 percent.

The Minimum Standards resolution (Attachment C) describes the changes noted in this report and requests approval to revise the Minimum Standards effective January 1, 2017. With these recommendations in action, the Minimum Standards will:

- increase the OOP maximum amount to \$6,850;
- increase the medical deductible to \$2,000 and require employers to cover 100 percent of the deductible where either a fully employer-funded HSA or HRA is allowable that provides first-dollar coverage;
- decrease the prescription drug deductible to \$250;
- increase the in-network coinsurance limit to 30 percent;
- increase the copayment limit for a primary care visit to \$45;
- include language that preventive, wellness, and pre/post-natal care services are standardized by the ACA at no charge to the insured; and
- include language that other services are standardized by the ACA, and cost-sharing must conform to the standards listed above

Recommendations for New Minimum Standards

Benefit Requirement	Current Minimum Standard	Recommended Minimum Standard Revision
1. Premium Contribution	Employer pays 100%	Retain current Minimum Standard
2. Annual OOP Maximum	<ul style="list-style-type: none"> • In-Network: \$6,350 • Out-of-Network: Not specified <p>OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.); and</p> <p>Employer may offer a plan with a higher OOP maximum only if they combine it with a fully employer-funded HSA or HRA for the amount exceeding \$6,350.</p>	<ul style="list-style-type: none"> • In-Network: \$6,850 • Out-of-Network: Not specified <p>OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.); and</p> <p>Employer may offer a plan with a higher OOP maximum only if they combine it with a fully employer-funded HSA or HRA for the amount exceeding \$6,850.</p>
3. Regular (Medical Services) Deductible	<ul style="list-style-type: none"> • In-Network: \$1,500 • Out-of-Network: Not specified <p>Employer may offer a plan with a higher deductible only if they combine it with a fully employer-funded HSA or HRA for the amount exceeding \$1,500.</p>	<ul style="list-style-type: none"> • In-Network: \$2,000 • Out-of-Network: Not specified <p>The employer must cover 100% of the medical deductible and may do so with either a fully employer-funded HSA or HRA. The HSA or HRA must provide first dollar coverage.</p>
4. Prescription Drug Deductible	<ul style="list-style-type: none"> • In-Network: \$300 • Out-of-Network: Not specified 	<ul style="list-style-type: none"> • In-Network: \$250 • Out-of-Network: Not specified
5. Prescription Drug Coverage	Plan must provide drug coverage, incl. coverage of brand-name drugs.	Retain current Minimum Standard
6. Coinsurance Percentages	<ul style="list-style-type: none"> • In-Network: 80%/20% • Out-of-Network: 50%/50% 	<ul style="list-style-type: none"> • In-Network: 70%/30% • Out-of-Network: 50%/50%
7. Copayment for Primary Care Provider Visits	<ul style="list-style-type: none"> • In-Network: \$30 per visit. • Out-of-Network: Not specified 	<ul style="list-style-type: none"> • In-Network: \$45 per visit. • Out-of-Network: Not specified
8. Ambulatory Patient Services (Outpatient Care)	<ul style="list-style-type: none"> • When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: • Primary Care Provider: See Benefit Requirement #7 • Specialty visits: Not specified 	<p>Retain current Minimum Standard</p> <p>* Include language: “Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.”</p>

Benefit Requirement	Current Minimum Standard	Recommended Minimum Standard Revision
9. Preventive & Wellness Services	<ul style="list-style-type: none"> In-Network: Provided at no cost, per ACA rules. Out-of-Network: Subject to the plan's out-of-network fee requirements. 	<p>Retain current Minimum Standard</p> <p>* Include language: "Covered California provides a list of covered preventive services. These services are standardized by federal ACA rules at no charge to the member."</p>
10. Pre/Post-Natal Care	<ul style="list-style-type: none"> In-Network: Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules. Out-of-Network: Subject to the plan's out-of-network fee requirements. 	<p>Retain current Minimum Standard</p> <p>* Include language: "Covered California provides a list of covered pre/post-natal care services. These services are standardized by federal ACA rules at no charge to the member."</p>
11. Hospitalization	<ul style="list-style-type: none"> When coinsurance is applied See Benefit Requirement #6 When copayments are applied for these services: Not specified 	<p>Retain current Minimum Standard</p> <p>* Include language: "Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above."</p>
12. Mental Health & Substance Use Disorder Services, including Behavioral Health	<ul style="list-style-type: none"> When coinsurance is applied See Benefit Requirement #6 When copayments are applied for these services: Not specified 	<p>Retain current Minimum Standard</p> <p>* Include language: "Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above."</p>
13. Rehabilitative & Habilitative Services	<ul style="list-style-type: none"> When coinsurance is applied See Benefit Requirement #6 When copayments are applied for these services: Not specified 	<p>Retain current Minimum Standard</p> <p>* Include language: "Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above."</p>
14. Laboratory Services	<ul style="list-style-type: none"> When coinsurance is applied See Benefit Requirement #6 When copayments are applied for these services: Not specified 	<p>Retain current Minimum Standard</p> <p>* Include language: "Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above."</p>
15. Emergency Room Services & Ambulance	<p>Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.</p>	<p>Retain current Minimum Standard</p> <p>* Include language: "Coverage of these services are standardized under ACA"</p>

Benefit Requirement	Current Minimum Standard	Recommended Minimum Standard Revision
		<i>rules. Cost-sharing for these services are to conform to the requirements above."</i>
16. Other Services	The full set of covered benefits is based on the ACA list of Essential Health Benefits in conjunction with the Covered California EHB Benchmark plan .	<p>Retain current Minimum Standard</p> <p><i>* Include language: "Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above."</i></p>

Health Care Accountability Workgroup 2016 Members

Name	Organization
Mavis Asiedu-Frimpong	SFDPH
Greg Brown	International Association of Machinists
Patrick Chang	SFDPH
Trina de Joya	RAMS
Karen Frost	Larkin Street Youth Services
Emma Gerould	SEIU 1021
Cynthia Gomez	Local 2
Jerrica Hau	SFO-EQS
Mason Jeffry	Dolores Street Community Services
Lynn Jones	NFP Insurance Services Inc.
Karl Kramer	Living Wage Coalition
Frank Landin	SF Child Abuse Prevention Center
Debbi Lerman	SF Human Services Network
Larry Loo	Chinese Community Health Plan
Whitfield McTain	SEIU-USWW
Tim Paulson	SF Labor Council
Beverly Popek	OLSE
Svetlana Shumak	SFO
Glenda Villalta	UFCW 5

**Health Commission
City and County of San Francisco
Resolution No. 16-11**

AMENDING THE HEALTHCARE ACCOUNTABILITY ORDINANCE MINIMUM STANDARDS

WHEREAS, On July 1, 2001, the Healthcare Accountability Ordinance (HCAO) went into effect, requiring that employers doing business with the City provide health insurance coverage for their employees or pay a fee to offset costs for health care provided by the City and County of San Francisco to the uninsured; and

WHEREAS, The HCAO provides the Health Commission with the authority and responsibility to determine Minimum Standards for health plan benefits offered by City contractors and lessees, as well as certain subcontractors and subtenants; and,

WHEREAS, the HCAO requires that the Health Commission review the Minimum Standards at least every two years and make changes as necessary to ensure that they are consistent with the current health insurance market; and

WHEREAS, In September 2016, DPH convened the Minimum Standards Workgroup, with representatives from various entities including health insurance broker firms, health plans, employers, labor advocates, and others, with the task of making recommendations for a revised set of Minimum Standards; and

WHEREAS, This Workgroup met three times with the goal to review and make recommendations for changes to the Minimum Standards, with the goal to balance the needs of employers and employees that would ensure health insurance plan options for employers, retain comprehensive benefits for employees, and consider affordability for both; and

WHEREAS, Taking into consideration the Workgroup's recommendations, DPH produced a written report to be presented to the full Health Commission on October 18, 2016 with an explanation of the process and description of the recommendations; and

WHEREAS, A review of the current Minimum Standards against 111 plans on the small business market in 2016 found that only 30 percent of plans are compliant; with the changes recommended here, this increases to 52 percent compliance, and

WHEREAS, DPH supports the proposal developed in conjunction with the HCAO Minimum Standards Workgroup, as described fully in this resolution, and is respectfully requesting approval from the Health Commission;

THEREFORE, BE IT RESOLVED, That the Health Commission thanks the Minimum Standards Workgroup for its thorough and thoughtful engagement and collaboration to develop recommended changes to the HCAO Minimum Standards for the Health Commission's consideration; and be it

FURTHER RESOLVED, That the Health Commission approves the following revised Minimum Standards effective January 1, 2017 for the calendar years 2017 and for 2018:

Benefit Requirement	New Minimum Standard
1. Premium Contribution	Employer pays 100%
2. Annual OOP Maximum	<ul style="list-style-type: none"> • In-Network: \$6,850 • Out-of-Network: Not specified <p>OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.); and</p> <p>Employer may offer a plan with a higher OOP maximum only if they combine it with a fully employer-funded HSA or HRA for the amount exceeding \$6,850.</p>
3. Regular (Medical Services) Deductible	<ul style="list-style-type: none"> • In-Network: \$2,000 • Out-of-Network: Not specified <p>The employer must cover 100% of the medical deductible and may do so with either a fully employer-funded HSA or HRA. The HSA or HRA must provide first dollar coverage.</p>
4. Prescription Drug Deductible	<ul style="list-style-type: none"> • In-Network: \$250 • Out-of-Network: Not specified
5. Prescription Drug Coverage	Plan must provide drug coverage, including coverage of brand-name drugs.
6. Coinsurance Percentages	<ul style="list-style-type: none"> • In-Network: 70%/30% • Out-of-Network: 50%/50%
7. Copayment for Primary Care Provider Visits	<ul style="list-style-type: none"> • In-Network: \$45 per visit. • Out-of-Network: Not specified
8. Ambulatory Patient Services (Outpatient Care)	<ul style="list-style-type: none"> • When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: <ul style="list-style-type: none"> • Primary Care Provider: See Benefit Requirement #7 • Specialty visits: Not specified <p>Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.</p>
9. Preventive & Wellness Services	<ul style="list-style-type: none"> • In-Network: Provided at no cost, per ACA rules. • Out-of-Network: Subject to the plan's out-of-network fee requirements. <p>Covered California provides a list of covered preventive services. These services are standardized by federal ACA rules at no charge to the member.</p>
10. Pre/Post-Natal Care	<ul style="list-style-type: none"> • In-Network: Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules. • Out-of-Network: Subject to the plan's out-of-network fee requirements.

Benefit Requirement	New Minimum Standard
	<p>Covered California provides a list of covered pre/post-natal care services. These services are standardized by federal ACA rules at no charge to the member.</p>
<p>11. Hospitalization</p>	<ul style="list-style-type: none"> • When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified <p>Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.</p>
<p>12. Mental Health & Substance Use Disorder Services, including Behavioral Health</p>	<ul style="list-style-type: none"> • When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified <p>Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.</p>
<p>13. Rehabilitative & Habilitative Services</p>	<ul style="list-style-type: none"> • When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified <p>Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.</p>
<p>14. Laboratory Services</p>	<ul style="list-style-type: none"> • When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified <p>Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.</p>
<p>15. Emergency Room Services & Ambulance</p>	<p>Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.</p> <p>Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.</p>
<p>16. Other Services</p>	<p>The full set of covered benefits is based on the ACA list of Essential Health Benefits in conjunction with the Covered California EHB Benchmark plan.</p> <p>Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.</p>

I hereby certify that the San Francisco Health Commission adopted this resolution at its meeting of November 1, 2016.