



City and County of San Francisco
London Breed
Mayor

San Francisco Department of Public Health

Barbara A. Garcia, MPA
Director of Health

Office of Policy and Planning

MEMORANDUM

July 17th, 2018

To: Edward Chow, MD, President, and Members of the Health Commission

Through: Barbara A. Garcia, MPA, Director of Health

Through: Sneha Patil, Acting Director, Office Policy and Planning

From: Patrick Chang, Senior Health Program Planner, Office of Policy and Planning
Ajay Yalamanchi, Intern, Office of Policy and Planning

Re: Health Care Accountability Ordinance – Suggested Revisions to the Minimum Standards for 2019 and 2020

As required by the San Francisco Health Care Accountability Ordinance (HCAO), the Department of Public Health has recently undertaken a thorough biannual review of the current HCAO Minimum Standards in relation to the current health care insurance market in California. These Standards set the minimum requirements for a compliant health plan that employers subject to the HCAO must meet when providing their employees with a health plan. The attached report (Attachment A) describes the findings and recommendations made by the HCAO Minimum Standards Workgroup convened by DPH (Attachment C).

We respectfully request that you consider the Workgroup's recommendations, summarized in Attachment B to this report, and look forward to discussing the findings with the members of the Health Commission on July 17th, 2018. We have also attached a draft resolution (Attachment D), for your consideration to ensure the Standards are updated in time for the first of the New Year.

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:

- 1) **offer health insurance coverage that meets the entire set of Minimum Standards** to their employees who are working on a City contract or on property leased from the City, or
- 2) **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 agency for the HCAO. OLSE and DPH work closely together to ensure proper compliance among contractors and lessees. Not all contractors or lease-holders are subject to the HCAO, and when they meet one or more of the criteria, the contractor or lease-holder 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 sources other 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 FY18-19, the fee is \$5.15 per hour worked per employee up to \$206 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 2016, and they went into effect on January 1, 2017. Since 2004, it has been DPH's practice to convene a 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 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):

The Minimum Standards should be workable for a full two years. It is common for health insurers to modify plan design from year-to-year, sometimes significantly. Additionally, the health care environment continues to face significant uncertainty as a result of federal actions. Hence, the Minimum Standards should take into consideration not just current trends, but what could happen in the future. Regardless of the volatile environment, San Francisco remains steadfast in its commitment to preserving equitable health care access and affordable coverage.

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 both 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 needed health services.

¹ Office of Labor Standards & Enforcement (2018). Retrieved from <https://sfgov.org/olse/health-care-accountability-ordinance-hcao>

A. The HCAO Workgroup

Starting on April 18th, 2018, the Workgroup met four times, with the last meeting on May 31st. Patrick Chang, with the Office of Policy & Planning (OPP), chaired the committee, and Krishna Patel and Stephanie Monroe 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 C. All members of the Workgroup reviewed and accepted the recommendations in this report.

Lynn Jones, NFP Corp, 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

Due to recent federal efforts and executive orders to weaken the ACA, such as the repeal of the individual mandate and the ending of cost-sharing reduction (CSR) payments to insurers, the health care marketplace has become increasingly volatile. As such, expenditures are expected to continue rising for all parties in the health care system. Consider the following findings:

- **Health care expenditures are continuing to outpace overall inflation.** In 2018, personal health care costs are expected to increase 2.2 percent compared to a 1.9 percent increase in overall inflation.²
- **Monthly health care premiums are becoming less affordable.** The average monthly premium for the second lowest cost silver plan, known as the benchmark plan, increased by 37 percent in 2018 compared to the prior year. Similarly, the average monthly premium for the lowest cost

plan increased by 17 percent in 2018 compared to the prior year.³

- **Employees are shouldering a greater share of health care costs.** In 2001, employees paid for 39% of their health care costs with employers covering the rest. In 2017, that number is up to 43%.⁴

Employees continue paying 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% 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 as important as 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 170 small group health plans from Q2 2018 (Table 1) to assist in developing its recommendations. 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.

² US Department of Labor (2018). Retrieved from <https://www.bls.gov/news.release/cpi.nr0.htm>

³ DHHS. ASPE Research Brief (2017). Retrieved from https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf

⁴ 2017 Milliman Medical Index (2017). Retrieved from <http://www.milliman.com/insight/Periodicals/mmi/2017-Milliman-Medical-Index/>

TABLE 1: Summary of Plans Analyzed by 2018 Workgroup

Carrier	Bronze	Silver	Gold	Platinum	Total
Aetna	6	2	3	0	11
Anthem Blue Cross	5	6	8	3	22
Blue Shield	6	5	8	7	26
California Choice	8	10	8	7	33
Chinese Community Health Plan	2	2	2	4	10
Health Net	4	8	8	6	26
Kaiser	3	4	4	3	14
Sutter Health Plus	2	2	3	3	10
United Healthcare	3	6	4	5	18
Total	39	45	48	38	170

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 all of the Minimum Standards. The Workgroup reviewed a range of 2018 small group plans across nine carriers, and generally 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 16 different variations on the standards against the small group plans.

Given this review and analysis, the Workgroup recommends:

- **All gold- and platinum-level plans** are automatically deemed compliant;
- **Changes to three (3) cost-sharing limits;**
- **Amended language to five (5) of the Minimum Standards;** and
- **Adding clarifying language that preventive/wellness services, pre-/post-natal care, and other covered services** (Minimum Standards 9, 10, and 16, respectively) are standardized to the California Essential Health Benefits (EHB) Benchmark Plan.

A side-by-side comparison of the current Standards and the Workgroup's recommendations is contained in Attachment B. 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 maintaining health insurance coverage. According to the Kaiser Family Foundation, the cost of single coverage premiums rose by four percent in 2017. In the same year, employee wages increased by only 2.3 percent.⁵ 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 to best ensure employees' access to affordable health coverage.

Recommendation: Retain the current Minimum Standard.

Minimum Standard 2: Annual Out-of-Pocket Maximum

- **In-Network:** *No higher than a \$6,850 maximum, including all types of employee cost sharing (deductible, copayments, coinsurance, etc.). Employer may offer a plan with a higher Out-of-Pocket maximum only if they combine it with a fully employer-funded health savings account (HSA) or health reimbursement account (HRA) for the amount exceeding \$6,850.*
- **Out-of-Network:** *Not specified.*

Nearly all health insurance plans set a specific Out-of-Pocket (OOP) maximum, which limits the insured's financial liability for the plan year. The amount an insured person pays during the year in deductibles, coinsurance, copayments, and other cost-sharing cannot exceed the OOP maximum. The current ACA annual OOP maximum is \$7,350, and it is set to increase to \$7,900 for 2019.⁶

⁵ The Kaiser Family Foundation (2017). Employer Health Benefits: 2017 Summary of Findings. Retrieved from <http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2017>

⁶ Department of Health and Human Services (2018). Retrieved from <https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019>

With OOP maximums increasing annually, this topic was discussed at length by Workgroup members. In order to balance employer plan availability and coverage affordability, the Workgroup agreed to adopt the *California Patient-Centered Benefit Design* OOP limit for a silver coinsurance or copay plan for 2019 and 2020.

By attaching this Minimum Standard to a state benchmark, it provides greater predictability for employers to anticipate and prepare for subsequent plan years while allowing them to access a larger number of plans. Additionally, this limit is historically lower than the ACA maximum which can provide workers some protection from larger increases each year.

Recommended New Minimum Standard: Sync the allowable OOP maximum to the California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan's effective date.

Minimum Standard 3: Medical Services Deductible

- ***In-Network:*** No higher than a \$2,000 maximum. 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.
- ***Out-of-Network:*** Not specified.

The Workgroup reached consensus on maintaining a \$2,000 deductible, and employers must continue covering 100% of actual expenditures that count towards the deductible, regardless of plan type and level. Language was amended to clarify that employers can use any health savings or reimbursement product, and there is no requirement to pre-fund the full amount for all employees. 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 health savings or reimbursement product will enable employers to receive tax advantages and possibly have unused funds revert back to their ownership.

DPH and OLSE will partner on developing guidance materials to support employers in complying with this standard.

Recommended New Minimum Standard:

Retain the current Minimum Standard, but amend the language to reflect that the employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard.

Minimum Standard 4: Prescription Drug Deductible

- ***In-Network:*** No higher than a \$250 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. Most recent data indicates that outpatient prescription drug spending accounts for approximately 10% of total health expenditures in the US.⁷

Analysis of the 170 sample health plans against various Minimum Standard configurations was conducted to produce a balance between prescription drug deductible affordability and plan availability. With a \$200 prescription drug deductible, nearly 40% of silver-level plans are compliant for some cost-sharing configurations. The Workgroup came to consensus on decreasing the prescription drug deductible to \$200 to not only better reflect market rates, but also to promote affordability in the face of a relatively high copayment and proposed increase in the OOP maximum.

Recommended New Minimum Standard:

Decrease the In-Network prescription drug deductible to \$200.

Minimum Standard 5: Prescription Drug Coverage

- ***Plan must provide drug coverage, including coverage of brand-name drugs.***

⁷ Centers for Medicare and Medicaid Services (2018). Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

Formulary drugs are those included on the list of prescription drugs covered by a prescription drug plan. In 2016, 67% of covered employees in California and 84% nationally had three- or four-tier cost-sharing coverage for prescription drugs.⁸ 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:** 70% / 30%
- **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% of costs for bronze, 70% for silver, 80% for gold, and 90% 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.

Of the 170 sample plans reviewed, the majority of silver and gold plans have coinsurance rates at or below 20%, and reducing the allowable maximum from 30% would not exert a negative influence on the number of compliant plans available to choose from. The Workgroup came to consensus on decreasing the coinsurance limit to better reflect rate trends and help offset other more expensive cost-sharing elements, such as the OOP maximum and copayment.

Recommended New Minimum Standard:
Decrease the In-Network coinsurance percentage to 80% / 20%.

Minimum Standard 7: Copayment for Primary Care Provider Visits

- **In-Network:** \$45 per visit
- **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 bronze and silver tier plans that the Workgroup reviewed require an office visit copayment of \$45 or above. It is important to note that some Workgroup members expressed concerns of \$45 being too high of an out-of-pocket cost and potentially a financial deterrent for employees that need to seek out healthcare services. Some Workgroup members indicated strong interest in further exploring avenues to reduce the financial impact of high copays for low-wage workers. At the same time, lowering the copayment limit would severely restrict the number of more affordable plans that employers can choose from. Taken with the recommendation for the employer to cover 100% of the medical deductible, the Workgroup agreed to retain the copayment limit in concert with reductions to other cost-sharing elements.

Recommendation: Retain the current Minimum Standard.

Minimum Standards 9 & 10 Preventive & Wellness Services

- **In-Network:** *Provided at no cost, per ACA rules.*
- **Out-of-Network:** *Subject to the plan’s out-of-network fee requirements.*

Pre/Post-Natal Care

- **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.*

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. However, due to concerns that the current federal administration is attempting to erode benefit standards and requirements, the Workgroup came to consensus that the services described in these Minimum Standards should be based on those outlined by California’s EHB Benchmark Plan. Anchoring these services to the California EHB Benchmark Plan may provide employees some protection against the uncertainty surrounding the federal administration’s outlook and potential modifications to benefits standards and requirements in the future.

⁸ California Health Care Foundation (2017). Retrieved from <https://www.chcf.org/publication/california-employer-health-benefits-prices-up-coverage-down/>

In addition, 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 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 maintaining language for 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 amend the language to reflect that these services are outlined by the California EHB Benchmark Plan.

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***

The Workgroup reached consensus on retaining these Minimum Standards with amended language for Standards 15 and 16. Members recommended that in-network copayments be included in the language to underscore all the types of cost-sharing when receiving emergency services from an out-of-network provider. In addition, members recommended that other covered services be defined by the California EHB Benchmark plan to avoid the uncertainty that comes from basing standards and requirements on federal ACA rules.

Recommended New Minimum Standard: Retain the current Minimum Standards. For Standard 15, include language indicating that in-network copayments also apply to emergency services received from an out-of-network provider. For Standard 16, amend the language to reflect that the full set of covered benefits is defined by the California EHB Benchmark Plan.

IV: Other Items

While beyond the scope of the Workgroup and the proposed resolution, some members expressed an interest in convening a separate Workgroup to discuss extending health benefits under the HCAO to dependents, spouses, and domestic partners of employees and providing funding to non-profit service contractors to provide family health care coverage. Because the ordinance currently pertains only to individual coverage for the employee, any recommendations developed by a workgroup would require a separate legislative process through the Board of Supervisors to consider and act on possible amendments to the law.

Some Workgroup members also expressed concern for whether non-profits across the city are being sufficiently funded to afford increased insurance costs and the potential impacts on cost-sharing for employees.

V: 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 city’s workforce. As ACA regulations change and 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 presidential executive actions, there was wider interest in anchoring the Standards to state benchmarks which may provide more comprehensive protections than federal rules.

The HCAO Workgroup considered numerous options, and these recommendations represent the consensus of its members. In reviewing 170 small business plans available on the small group insurance market, only 48% are compliant with the current standards. The recommendations noted in this report increase the number of compliant plans to 60%.

With these recommendations, the Minimum Standards will:

- result in all gold- and platinum-level plans being compliant;

- base the OOP maximum on the California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan;
- continue requiring employers to cover 100% of actual expenditures that count towards the medical deductible, and allow the use any health savings/reimbursement product to comply with this Standard;
- decrease the allowable prescription drug deductible to \$200;
- decrease the allowable in-network coinsurance limit to 20%;
- amend the language to reflect that preventive, wellness, and pre-/post-natal care services are outlined by the California EHB Benchmark Plan;
- amend the language to reflect that in-network copayments also apply to emergency services received from an out-of-network provider; and
- amend the language to reflect that other covered services are defined by the California EHB Benchmark Plan.

The Minimum Standards resolution (Attachment D) describes the changes noted in this report. DPH respectfully requests approval to revise the Minimum Standards effective January 1, 2019.

Recommendations for New Minimum Standards, 2019-2020

The following summarizes the Workgroup's review and recommendations for the Minimum Standards effective January 1, 2019 through December 31, 2020. A health plan must meet all 16 minimum standards to be deemed compliant. Underlined text indicates additions or changes.

Benefit Requirement	Current Minimum Standard	Recommended Revision
Type of Plan	Any type of plan that meets the Minimum Standards as described below.	Any type of plan that meets the Minimum Standards as described below. <u>All gold- and platinum-level plans are deemed compliant.</u>
1. Premium Contribution	Employer pays 100%	Retain current Minimum Standard
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>	<ul style="list-style-type: none"> • In-Network: <u>California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan's effective date:</u> <u>2019 = \$7,550</u> <u>2020 = To be determined in 2019</u> • Out-of-Network: Not specified <p>OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.)</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>	<ul style="list-style-type: none"> • In-Network: \$2,000 • Out-of-Network: Not specified <p>The employer must cover 100% of <u>actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard.</u></p>
4. Prescription Drug Deductible	<ul style="list-style-type: none"> • In-Network: \$250 • Out-of-Network: Not specified 	<ul style="list-style-type: none"> • In-Network: <u>\$200</u> • Out-of-Network: Not specified
5. Prescription Drug Coverage	Plan must provide drug coverage, including coverage of brand-name drugs.	Retain current Minimum Standard
6. Coinsurance Percentages	<ul style="list-style-type: none"> • In-Network: 70%/30% • Out-of-Network: 50%/50% 	<ul style="list-style-type: none"> • In-Network: <u>80%/20%</u> • Out-of-Network: 50%/50%

Benefit Requirement	Current Minimum Standard	Recommended Revision
7. Copayment for Primary Care Provider Visits	<ul style="list-style-type: none"> • In-Network: \$45 per visit. • Out-of-Network: Not specified 	Retain current Minimum Standard
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 	Retain current Minimum Standard
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>	<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>These services are standardized by federal ACA rules at no charge to the member. The California EHB Benchmark Plan outlines the types of preventive services that are required.</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>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>	<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>These services are standardized by federal ACA rules at no charge to the member. The California EHB Benchmark Plan outlines the types of pre- and post-natal services that are required.</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 	Retain current Minimum Standard
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 	Retain current Minimum Standard
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 	Retain current Minimum Standard

Benefit Requirement	Current Minimum Standard	Recommended Revision
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 	Retain current Minimum Standard
15. Emergency Room Services & Ambulance	Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.	Limited to treatment of medical emergencies. The in-network deductible, <u>copayment</u> , and coinsurance also apply to emergency services received from an out-of-network provider.
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.	The full set of covered benefits is defined by the California EHB Benchmark plan .

Health Care Accountability Workgroup 2018 Members

Name	Organization
Greg Brown	IAM-DIST141
David Canham	SEIU 1021
Trina de Joya	Richmond Area Multi-Services, Inc.
Karen Frost	Larkin Street Youth Services
Rudy Gonzalez	SF Labor Council
Jerrica Hau	SFO-EQS
Mason Jeffrys	Dolores Street Community Services
Lynn Jones	NFP Corp
Karl Kramer	SF Living Wage Coalition
Debbi Lerman	SF Human Services Network
Ian Lewis	UNITE HERE Local 2
Larry Loo	Chinese Community Health Plan
Beverly Popek	Office of Labor Standards and Enforcement

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

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 that meets all the Minimum Standards 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 April 2018, 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 four 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 July 17th, 2018 with an explanation of the process and description of the recommendations; and

WHEREAS, A review of the current Minimum Standards against 170 plans on the small business market in 2018 found that only 48 percent of plans are compliant; with the changes recommended here, including that all gold and platinum level plans be deemed automatically compliant, this increases the share of compliant plans to 60 percent; 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 for the calendar years 2019 and 2020:

Benefit Requirement	New Minimum Standard
Type of Plan	Any type of plan that meets the Minimum Standards as described below. All gold- and platinum-level plans are deemed compliant.
1. Premium Contribution	Employer pays 100%
2. Annual OOP Maximum	<ul style="list-style-type: none"> • In-Network: California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan's effective date: 2019 = \$7,550 2020 = To be determined in 2019 • Out-of-Network: Not specified <p>OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.).</p>
3. Medical Deductible	<ul style="list-style-type: none"> • In-Network: \$2,000 • Out-of-Network: Not specified <p>The employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard.</p>
4. Prescription Drug Deductible	<ul style="list-style-type: none"> • In-Network: \$200 • 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: 80%/20% • 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: • Primary Care Provider: See Benefit Requirement #7 • Specialty visits: Not specified
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>These services are standardized by federal ACA rules at no charge to the member. The California EHB Benchmark Plan outlines the types of preventive services that are required.</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>These services are standardized by federal ACA rules at no charge to the member. The California EHB Benchmark Plan outlines the types of pre- and post-natal services that are required.</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>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>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>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>15. Emergency Room Services & Ambulance</p>	<p>Limited to treatment of medical emergencies. The in-network deductible, copayment, and coinsurance also apply to emergency services received from an out-of-network provider.</p>
<p>16. Other Services</p>	<p>The full set of covered benefits is defined by the California EHB Benchmark plan.</p>