



City and County of San Francisco
London N. Breed
Mayor

San Francisco Department of Public Health
Grant Colfax, MD
Director of Health

Office of Policy and Planning

MEMORANDUM

July 7th, 2020

To: Dan Bernal, President, and Members of the Health Commission

Through: Grant N. Colfax, MD, Director of Health
Naveena Bobba, MD, Deputy Director of Health

Through: Sneha Patil, Director, Office Policy and Planning

From: Patrick Chang, Senior Health Program Planner, Office of Policy and Planning
Sierra Nesbit, Intern, Office of Policy and Planning

Re: Health Care Accountability Ordinance – Suggested Revisions to the Minimum Standards for 2021 and 2022

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 7th, 2020. 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, or
- 3) **pay an additional amount per hour worked to the employee who performs work not located in the City, the San Francisco Airport, or at the San Bruno Jail.**

The law applies to non-profit employers with 50 or more employees and contract amounts exceeding \$50,000, along with for-profit employers with 20 or more employees and contracts exceeding \$25,000. 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 or pay the covered employee directly if work is performed outside of the City, not at the San Francisco Airport, or the San Bruno Jail. For FY20-21, the fee is \$5.60 per hour worked per employee up to \$224 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 2018, and went into effect on January 1, 2019. 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, 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):

Workgroup members sought to develop a set of recommendations to revise the Minimum Standards that would provide an array of affordable 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. This set of revisions to the Minimum Standards was selected to ensure that employers have access to a greater amount of affordable silver and gold plans. If the premium costs to the employer are set too high, the employer may be 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 (2020). Retrieved from <https://sfgov.org/olse/health-care-accountability-ordinance-hcao>

When developing the Minimum Standards, one of the central objectives to the process is to ensure the standards are 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 ongoing federal actions to weaken and strike down the Affordable Care Act (ACA) and the global COVID-19 pandemic's impact on healthcare utilization and delivery. It is important that both employers and employees have affordable plans to choose from.

A. The HCAO Workgroup

Starting on April 22nd, 2020, the workgroup met four times, with the last meeting on June 3rd. Patrick Chang, with the Office of Policy & Planning (OPP), chaired the committee, and Sierra Nesbit from OPP provided additional support. Many of this year's workgroup members participated in previous years and some participated in the drafting of the original ordinance. Other members 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, formerly with NFP CA Insurance Services, Inc, and Wil Yu, 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

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. Despite overall expansions in coverage, as health care costs continue to rise in the United States, the amount of people who are underinsured due to a lack of affordability is also of serious concern. These steep costs are impacting consumer choices in seeking health care services. For example, recent surveys indicate that a record 1 in 4 Americans say they or a family member put off treatment for a medical condition in the past year because of the cost.² The growth in out-of-pockets costs come at a time when wages have been largely stagnant.³ Additionally, patient deductibles have increased 162 percent compared to a 26 percent rise in workers' wages over the past decade.⁴

Monthly health care premiums are becoming less affordable. Since the enactment of the ACA, fewer people are uninsured, but many remain underinsured due to the high cost of premiums. From 2009 to 2019, premiums for employer-sponsored coverage increased 54 percent compared to 20 percent for overall inflation. For 2020, employer health insurance costs are projected to rise another 6.5 percent, more than double the projected rate of inflation of 2.7 percent. This is also seen in the individual market where the average monthly premium for the second lowest cost silver plan, known as the benchmark plan, was 85 percent higher in 2019 than it was in 2014.⁵

In response to this trend, some workgroup members have emphasized that it has become increasingly difficult over the years to ensure there are reasonably affordable options for both employers and employees. Employers must be able to afford the premium and medical deductibles of the plans they choose for their employees. Conversely, the out-of-pocket cost of the plan must be affordable to the employees so a significant proportion of workers are able to afford using services.

COVID-19 may significantly impact healthcare access and costs. Though the net outcome of the pandemic on healthcare access and costs remains uncertain, findings estimate there may be a significant impact on the healthcare system given the cost increase from direct COVID-19 care, such as paying hospital staff overtime and purchasing personal protective equipment, in tandem with decreased revenues from deferred and foregone

² Saad, L (2019). More Americans Delaying Medical Treatment Due to Cost. Gallup. Retrieved from <https://news.gallup.com/poll/269138/americans-delaying-medical-treatment-due-cost.aspx>

³ Peterson-Kaiser Health System Tracker (2019). Tracking the rise in premium contributions and cost-sharing for families with large employer coverage. Retrieved from

<https://www.healthsystemtracker.org/>

⁴ Kaiser Family Foundation (2019). Employer Health Benefits. Retrieved from

<https://www.kff.org/report-section/ehbs-2019-summary-of-findings>

⁵ DHHS. ASPE Research Brief (2019). Retrieved from

<https://aspe.hhs.gov/system/files/pdf/260041/2019LandscapeBrief.pdf>

services.⁶ Since the pandemic began, the incoming revenue from elective procedures and routine health visits has dropped significantly as a result of more individuals remaining at home, as a safety precaution.

In the Bay Area, physicians have recently voiced concern over the potential long-term health impacts on local residents as a result of delaying scheduled vaccinations and routine screenings for serious conditions, such as heart disease and cancer.⁷ Furthermore, the AHA estimates a total four-month financial impact of \$202.6 billion in losses for America's hospitals and health systems.⁸

Moreover, roughly half of the US population and an estimated 54 percent of Californians receive health coverage through an employer.⁹ As unemployment rates climb, those who receive health insurance through their employers risk losing their coverage if laid off from their jobs. Some models predict that if unemployment reaches 20 percent in California, more than 3 million workers could lose their employer-based coverage. Of those 3 million, models estimate that about half (1.7 million) would gain coverage through Medi-Cal. While some individuals would obtain other private coverage, an estimated 649,000 individuals would remain uninsured, and unemployed workers and their dependents may face increased difficulty accessing care.¹⁰

Uncertainty around the future of the ACA endures.

Since the federal Affordable Care Act (ACA) was signed into law in 2010, nearly 1.7 million previously-uninsured Californians have gained health insurance coverage despite the incumbent federal administration's efforts to dismantle the law.¹¹ In San Francisco alone, an estimated 140,000 people have enrolled in new insurance options.¹²

However, ongoing federal efforts and executive orders have attempted to weaken the ACA - such as the U.S. Supreme Court's recent acceptance of

multiple appeals, which may ultimately decide the fate the ACA. Additionally, there have been numerous repeals of the law's provisions that were enacted as part of the Further Consolidated Appropriations Act, 2020. This Act was a large spending bill that was passed by the White House in December 2019, which authorized appropriations to fund the operation of certain Federal agencies through September of 2020. Under the Act, some modifications to the ACA included a repeal of the "Cadillac Tax," a tax on high-cost health plans designed to drive down health care spending, and the ACA Health Insurance Tax, which has been applied to insurance carriers over the last several years.^{13,14}

C. Health Plan Review

The workgroup evaluated 160 small group health plans from Q2 2020 to assist in developing its recommendations (Table 1). California defines a small business as having 100 or fewer employees for the purposes of health insurance. DPH analyzed 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.

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 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

⁶ 2020 Milliman Medical Index (2020). Retrieved from <https://www.milliman.com/en/insight/2020-milliman-medical-index>

⁷ Moench, M. (2020). Bay Area doctors worry about patients skipping preventive medical care during coronavirus pandemic. Retrieved from <https://www.sfchronicle.com/bayarea/article/Bay-Area-doctors-worry-about-patients-skipping-15348042.php>

⁸ American Hospital Association Covid-19 Updates (2020). Retrieved from <https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf>

⁹ Kaiser Family Foundation (2019). Employer Sponsored Coverage Rates for the Non-elderly by Age. Retrieved from: <https://www.kff.org/other/state-indicator/rate-by-age-2/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹⁰ Garrett, A. Bowen and Gangopadhyaya, Anuj, How the COVID-19 Recession Could Affect Health Insurance Coverage (May 4, 2020). Retrieved from <http://dx.doi.org/10.2139/ssrn.3598558>

¹¹ Tolbert, J, Orgera, K, Singer, N, & Damico, A (2019). Key Facts about the Uninsured Population. Kaiser Family Foundation. Retrieved from <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/view/footnotes/>

¹² Department of Public Health (2019). San Francisco's Health Insurance Trends & Estimates, 2019. Retrieved from <https://www.sfdph.org/dph/files/reports/default.asp>

¹³ White House Budget & Spending (2019). Retrieved from <https://www.whitehouse.gov/briefings-statements/>

¹⁴ Affordable Care Act Updates for January 2020. Retrieved from <https://www.sikich.com/insight/affordable-care-act-updates-january-2020/>

TABLE 1: Summary of Plans Analyzed by 2020 Workgroup

Carrier	Bronze	Silver	Gold	Platinum	Total
Aetna	2	3	5	2	12
Anthem Blue Cross	6	7	7	4	24
Blue Shield	5	5	8	6	24
California Choice	4	9	8	6	27
Chinese Community Health Plan	2	2	2	4	10
Health Net	2	5	9	5	21
Kaiser	2	4	3	2	11
Sutter Health Plus	2	2	3	3	10
United Healthcare	2	5	8	6	21
Total	27	42	53	38	160

minimizing the negative impact of increasingly high deductibles on workers, the workgroup analyzed seven different variations on the standards against the small group plans.

Given this review and analysis, the workgroup recommends the following revisions to the current Minimum Standards:

- All gold and platinum level plans continue to be deemed automatically compliant, and clarify with added language stating this allowance applies only to plans written in California; and
- Changes to three cost-sharing limits.

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 California Health Care Foundation, in 2018, the average annual premium cost for a single employee in California increased 4.5 percent from 2017.¹⁵ In the same year, employee wages increased by only 3.3 percent, slightly above the national average.¹⁶ Given that all types of health care costs continue to rise, 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.

¹⁵ California Health Care Foundation (2019). California Employer Health Benefits. California Health Care Almanac Quick Reference Guide. Retrieved from <https://www.chcf.org/resource/california-health-care-almanac/>

¹⁶ U.S. Bureau of Labor Statistics (2018). Retrieved from

Recommendation: Retain the current Minimum Standard.

Minimum Standard 2: Annual Out-of-Pocket Maximum

- ***In-Network:*** California Patient-Centered Benefit Design out-of-pocket limit for a silver coinsurance or copay plan during the plan's effective date:
- ***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 \$8,150, and it is set to increase to \$8,550 for 2021.¹⁷

Beginning in 2019, the workgroup agreed to tie the OOP maximum to the amount set by the California Patient-Centered Benefit Design (PCBD) OOP benchmark for a silver coinsurance or copay plan. This decision to sync the Minimum Standard to a state benchmark 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 state benchmark is historically lower than the ACA maximum and provides healthcare consumers with some protection from the annual increase. For example, in 2019, the out-of-pocket limit set by the ACA was \$7,900, while the PCBD limit was \$7,550. For

https://www.bls.gov/regions/west/news-release/countyemploymentandwages_california.htm

¹⁷ Cigna (2020). Retrieved from <https://www.cigna.com/employers-brokers/insights/informed-on-reform/cost-sharing>

2020, the ACA limit was \$8,200 compared to the PCBD limit of \$7,800. In 2021, the approved increase to this CA benchmark is \$8,200 or \$350 less than the proposed federal limit.¹⁸

Recommendation: Retain the current Minimum Standard.

Minimum Standard 3: Medical Services Deductible

- ***In-Network:*** No higher than a \$2,000 maximum.

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.

- ***Out-of-Network:*** Not specified.

A medical deductible is the amount a healthcare consumer must pay out-of-pocket before the insurance plan begins to pay for services. After reviewing the Q2 2020 small group plan data, the workgroup agreed there was a need to increase the amount of silver plans available to employers, especially considering there were no silver plans currently compliant with the current Minimum Standards. Only 17 silver plans had a medical deductible at or below \$2,000, while all 42 silver plans had a medical deductible at or below \$3,000.

The workgroup reached consensus on maintaining the requirement that employers must cover any employee OOP expenses that count towards this deductible while increasing the allowable medical deductible from \$2,000 to \$3,000. This benefits employees by protecting them from high deductibles, while allowing employers to choose from a greater number of plans with higher deductibles and lower premiums.

Recommended New Minimum Standard: Increase the maximum for an In-Network medical deductible to \$3,000.

Minimum Standard 4: Prescription Drug Deductible

- ***In-Network:*** No higher than a \$200 deductible.
- ***Out-of-Network:*** Not specified.

Similar to a deductible for medical services, some plans include a prescription drug deductible, which is the amount a consumer must pay for covered prescription drugs before the insurance plan begins to pay.

Costs for prescription drugs continue to increase and outpace the costs for other medical services. Retail prescription drug spending increased 2.5 percent in 2018, as compared to 1.4 percent growth in 2017. Additionally, most recent data indicates that outpatient prescription drug spending accounts for approximately nine percent of total health expenditures in the US.¹⁹

From 2018 to 2020, the prescription drug deductible for many silver plans has increased from \$200 to \$300, respectively. Analysis of the 160 sample health plans against various Minimum Standard configurations was conducted to produce a balance between prescription drug deductible affordability and plan availability. Among those silver plans with a drug deductible, only two of them have a deductible that is at or below the current Minimum Standard of \$200. With a higher prescription drug deductible of \$300, nearly 55 percent of silver-level plans are compliant for some cost-sharing configurations. The workgroup came to consensus on increasing the prescription drug deductible from \$200 to \$300 to expand the amount of silver plans available to employers.

Recommended New Minimum Standard: Increase the In-Network prescription drug deductible to \$300.

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 2017, 59 percent of covered employees in California and 84 percent nationally had three- or four-tier cost-sharing coverage for prescription drugs. Consumers with four-tier cost-sharing

¹⁸ Covered California 2021 Patient-Centered Benefit Plan Designs https://www.hbex.ca.gov/stakeholders/planmanagement/PDFs/final_2021_standard_benefit_plan_designs_20190601.pdf

¹⁹ 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>

coverage are exposed to the greatest financial risk.²⁰

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 the deductible amount is met. Under the ACA, the use of metal tiers to standardize a plan's actuarial value 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.

After examining the different variations of plans available, the workgroup agreed that coinsurance is the area in which healthcare consumers may face the highest OOP costs after the deductible, given that the overall cost of a visit, procedure, or treatment may be largely unknown until after a visit. However, with a set copay, the healthcare consumer knows the amount they will be required to pay for a primary care visit upfront. Based on this rationale, the workgroup favored choosing a set of Minimum Standards with a raised copay, as compared to a raised coinsurance percentage, to provide the most protection from high OOP costs.

Of the 160 sample plans reviewed, the majority of silver and gold plans have coinsurance rates at or below 20 percent, creating no immediate need to increase the coinsurance to 30 percent as per the market trends. The workgroup came to consensus to maintain the coinsurance limit to promote affordability in the face of proposed increases in copayment, prescription drug deductibles, and OOP maximum.

Recommendation: Retain the current Minimum Standard.

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 healthcare service after the deductible is met. Since 2018, overall trends in cost-sharing are reflected in an increase to copayments for primary care visits. Although 71 percent of plans analyzed have a copayment at or below the current HCAO limit of \$45, only one bronze and five silver plans meet that standard. In an effort to include a wider range of silver plan options for employers to choose from, the workgroup ultimately came to the consensus to raise this copayment from \$45 to \$50.

It is important to note that many workgroup members expressed concerns of \$50 being too high of an OOP cost and potentially a financial deterrent for employees that need to seek out primary care services. At the same time, maintaining the copayment limit of \$45 would severely restrict the number of more affordable plans that employers can choose from. Considering the Minimum Standard that the employer covers 100 percent of the medical deductible along with the maintenance of the 20 percent coinsurance, the workgroup agreed to increase the copayment limit to balance the financial responsibility between the employer and employee.

Lastly, it is also important to note that under the ACA, all patients are entitled to a free annual wellness visit, meaning this copayment would only be applied to all visits thereafter.

Recommended New Minimum Standard:
Increase the copayment limit to \$50.

Minimum Standard 8, 11-16

- ***Ambulatory Patient Services (Outpatient Care)***
- ***Hospitalization***
- ***Mental Health & Substance Use Disorder Services, including Behavioral Health***

²⁰ California Health Care Foundation (2018). Retrieved from <https://www.chcf.org/publication/california-employer-health-benefits-prices-up-coverage-down/>

- **Rehabilitative & Habilitative Services**
- **Laboratory Services**
- **Emergency Room Services & Ambulance**
- **Other Services**

The workgroup reached consensus in deciding to maintain these Minimum Standards.

Recommendation: Retain the current Minimum Standards.

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.*

The workgroup came to consensus that the services described in these Minimum Standards should continue to be based on those outlined by California's EHB Benchmark Plan, as recommended by the 2018 workgroup. The notion was that basing these services on 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 by the current federal administration.

Recommendation: Retain the current Minimum Standard.

IV: Other Items

The following items represent other discussion themes that came up during workgroup meetings.

A. Coverage for COVID-19 Testing and Services

Though the long-term impacts of COVID-19 on healthcare costs are difficult to predict at this time, findings strongly suggest that there may be a significant financial impact on all parties involved in the healthcare system.

While beyond the scope of the workgroup and the proposed resolution, some members expressed an interest in exploring legislative amendments to the ordinance or urging other governmental declarations to extend coverage access for employees who are laid off or furloughed during the public health emergency.

Additionally, there was a discussion among workgroup members on if and/or how to implement a Minimum Standard specifically related to fully covering COVID-19 testing and care. Some members pointed out that – pursuant to state and federal orders – insurance carriers are generally covering 100 percent of diagnostic testing and screening, but this may change when the state declaration requiring this coverage sunsets and COVID-19 becomes a “normal” standard of care for seasonal viruses (e.g., annual vaccine). If this happens, then cost sharing may shift away from 100 percent coverage by insurance carriers, thus potentially causing group plans to no longer be compliant under the Minimum Standards. From an insurance perspective, there are too many unknowns as to how services for COVID-19 will be handled moving forward. This notion guided the workgroup's decision to not include COVID-19 care as either an additional Standard or a modification to Standard 16.

Considering all of this, the workgroup strongly encourages the City and County of San Francisco to advocate for the State of California to continue providing waivers to cover COVID-19-related care for as long as needed. As the pandemic continues, DPH may review small group plan data regarding how COVID-19 care is being covered (coinsurance, deductible, etc.), and if warranted, DPH may consider examining coverage of COVID-19 testing and services in relation to the HCAO.

B. Family Coverage

While beyond the reach of the ordinance and scope of the workgroup, some members expressed interest in discussing the relationship of the HCAO and Minimum Standards for an employer who offers coverage for dependents. Others touched on the role of an organization's budget and financial constraints, alternative standards for employers who offer dependent coverage, and the difference between improving coverage versus expanding coverage. In the interest of extending coverage to workers' family members, one idea put forth was deeming an employer as complying with the HCAO if they offered the individual employee a silver plan that also provided family coverage at no premium

cost to the worker.

C. Funding for Non-Profits

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, especially during the current economic environment where non-profits may face a 10-15 percent reduction in revenues over the next two fiscal years in line with budget cuts to city agencies. Non-profit organizations may also be unable to raise prices for providing services during a contract period in order to generate additional revenue as for-profit entities can.

- increase the allowable prescription drug deductible to \$300;
- maintain the allowable in-network coinsurance limit at 20 percent; and
- increase the primary care provider visit copayment to \$50

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, 2021.

V: Conclusion

DPH continues to support 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. The health insurance marketplace continues to adjust for increasing costs, which may increase further with COVID-19, by shifting a greater proportion of OOP expenses to consumers in the form of deductibles, coinsurance, and copayments.

Finally, the HCAO Workgroup considered numerous options, and these recommendations represent the consensus of its members. In reviewing 160 plans currently available on the small group insurance market, only 40 percent are compliant with the current standards. The recommendations noted in this report increase the number of compliant plans to 52 percent.

With these recommendations, the Minimum Standards will:

- result in all gold- and platinum-level plans written only in CA as being compliant;
- continue basing 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 percent of actual expenditures that count towards the medical deductible, and increase the allowable medical deductible to \$3,000;

Recommendations for New Minimum Standards, 2021-2022

The following summarizes the workgroup's review and recommendations for the Minimum Standards effective January 1, 2021 through December 31, 2022. 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. All gold- and platinum-level plans are deemed compliant.	Retain current Minimum Standard regarding gold- and platinum-level plans. <u>Include language that this allowance only applies to plans written in California.</u>
1. Premium Contribution	Employer pays 100 percent	Retain current Minimum Standard
2. Annual Out-of-Pocket 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: • Out-of-Network: Not specified <p>OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.)</p>	Retain current Minimum Standard
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 percent 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>	<ul style="list-style-type: none"> • In-Network: <u>\$3,000</u> • Out-of-Network: Not specified <p>Maintain requirement that employers cover any employee out-of-pocket expenses that count towards this deductible.</p>
4. Prescription Drug Deductible	<ul style="list-style-type: none"> • In-Network: \$200 • Out-of-Network: Not specified 	<ul style="list-style-type: none"> • In-Network: <u>\$300</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: 80 percent/20 percent • Out-of-Network: 50 percent/50 percent 	Retain current Minimum Standard

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 	<ul style="list-style-type: none"> • In-Network: <u>\$50 per visit</u> • 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 	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>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>	Retain current Minimum Standard
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>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>	Retain current Minimum Standard
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, copayment, and coinsurance also apply to emergency services received from an out-of-network provider.	Retain current Minimum Standard
16. Other Services	The full set of covered benefits is defined by the California EHB Benchmark plan .	Retain current Minimum Standard

Health Care Accountability Workgroup 2020 Members

Name	Organization
Beverly Popek	Office of Labor Standards and Enforcement
Bill Wong	San Francisco International Airport (SFO)
Cynthia Gomez	Unite Here, Local 2
Debbi Lerman	SF Human Services Network
Greg Brown	IAM-DIST141
Karen Frost	Swords to Plowshares
Karl Kramer	SF Living Wage Coalition
Lynn Jones	NFP CA Insurance Services, Inc
Nolia Yulan Lai	Dolores Street Community Services (DSCS)
Rudy Gonzalez	San Francisco Labor Council (SFLC)
Trina de Joya	Richmond Area Multi-Services, Inc.
Wil Yu	Chinese Community Health Plan

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

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 2020, 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 purpose of reviewing and making 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, The workgroup recognizes the financial challenges experienced by both employers and employees during this global pandemic and subsequent economic crisis; and

WHEREAS, The workgroup emphasizes the importance of maintaining access to affordable and comprehensive care for employees, while ensuring that employers have access to quality health plans for their staff; and

WHEREAS, The workgroup understands that the COVID-19 pandemic exacerbates the existing health disparities in the community, laying the heaviest burden upon the most vulnerable populations in society; and

WHEREAS, Taking into consideration the workgroup's recommendations, DPH produced a written report to be presented to the full Health Commission on July 7th, 2020 with an explanation of the process and description of the recommendations; and

WHEREAS, A review of the current Minimum Standards against 160 plans on the small business market in 2020 found that only 40 percent of plans are compliant; with the changes recommended here, this increases the share of compliant plans to 52 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 2021 and 2020:

Benefit Requirement	New Minimum Standard
Type of Plan	<p>Any type of plan that meets all the Minimum Standards as described below.</p> <p>All gold- and platinum-level plans written in California are deemed compliant if the employer funding requirements and coverage for required services described below are satisfied.</p>
1. Premium Contribution	Employer pays 100 percent
2. Annual OOP Maximum	<ul style="list-style-type: none"> • <u>In-Network</u>: <i>California Patient-Centered Benefit Design</i> Out-of-Pocket limit for a silver coinsurance or copay plan during the plan’s effective date • <u>Out-of-Network</u>: 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"> • <u>In-Network</u>: \$3,000 • <u>Out-of-Network</u>: Not specified <p>The employer must cover 100 percent 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"> • <u>In-Network</u>: \$300 • <u>Out-of-Network</u>: 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"> • <u>In-Network</u>: 80 percent/20 percent • <u>Out-of-Network</u>: 50 percent/50 percent
7. Copayment for Primary Care Provider Visits	<ul style="list-style-type: none"> • <u>In-Network</u>: \$50 per visit • <u>Out-of-Network</u>: Not specified
8. Preventive & Wellness Services	<ul style="list-style-type: none"> • <u>In-Network</u>: Provided at no cost, per ACA rules. • <u>Out-of-Network</u>: Subject to the plan’s out-of-network fee requirements.

Benefit Requirement	New Minimum Standard
	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.
9. Pre/Post-Natal Care	<ul style="list-style-type: none"> • <u>In-Network</u>: Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules. • <u>Out-of-Network</u>: 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>
10. 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
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
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
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
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
15. Emergency Room Services & Ambulance	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.
16. Other Services	The full set of covered benefits is defined by the California EHB Benchmark plan .

I hereby certify that the San Francisco Health Commission adopted this resolution at its meeting of July 7, 2020. _____

Mark Morewitz, MSW
Health Commission Executive Secretary