



Health Care Accountability Ordinance

Minimum Standards Report – Review & Revisions

2014



I. HEALTH CARE ACCOUNTABILITY ORDINANCE OVERVIEW

A. HCAO Summary

In 2001, the San Francisco Board of Supervisors approved the Health Care Accountability Ordinance (HCAO). This legislation grew out of the Living Wage movement and the Minimum Compensation Ordinance (MCO). The MCO mandates a specific hourly wage that businesses contracting with the City and County of San Francisco (CCSF) must pay their employees. Both the HCAO and the MCO were the result of the recommendations made by the Living Wage Task Force, commissioned by the Board of Supervisors in 1998. The legislation became one of San Francisco's early successes in developing direct pathways to health insurance for residents who may otherwise have difficulty accessing affordable coverage.

Codified into law through San Francisco's Administrative Code, Chapter, 12Q, the HCAO went into effect on July 1, 2001. The HCAO applies to City and County of San Francisco (CCSF) contractors and certain tenants, such as those using space at the San Francisco International Airport (SFO) and the Port of San Francisco. It requires that these employers doing business with CCSF offer health insurance coverage to their employees who are working on a CCSF contract or on property leased from the City. This coverage must meet a current set of Minimum Standards. Alternatively, employers may pay a fee to the Department of Public Health (DPH) to offset the costs of health care provided to the uninsured through DPH's health care services section. In order to be compliant with HCAO, the employer must offer a plan (just one) that meets or exceeds the Minimum Standards. It is not required that the employee accept that plan.

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 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. Here are some of the most common reasons that an employer would not be subject to the HCAO:

- The business employs too few workers: 20 or fewer (for profit) or 10 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.

i. The Minimum Standards

The Health Commission has the sole authority to set the Minimum Standards. The HCAO notes in Section 12Q.3.(a)(1): "*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.*" 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.

In addition, 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. When compared to the plans on the small business market, only 24 percent of the plans meet the current Minimum Standards. This means that a review with recommendations for updates, such as the one undertaken and described here, is important to ensure that HCAO plays a role in helping workers have access to health coverage.

ii. Paying the fee

Employers that do not offer a health insurance plan that complies with the Minimum Standards are required to submit payments directly to DPH on a monthly basis. This fee is set through an automatic process using certain metrics set in the Ordinance. Effective July 1, 2013, the fee was \$4.00 per employee/per hour, and as of July 1, 2014 it was increased to \$4.25. The reasons for paying these fees vary widely; in some cases it is because the company's policy of the health insurance start date is not in keeping with what is required in the HCAO (no later than the first of the month that begins after 30 days from the start of employment). In other cases, employers pay for seasonal workers, or large payments as restitution required after an OLSE audit.

The past three years of data show that employers' payments have declined to some extent, which may imply that employers are finding it easier to comply with the HCAO. It is difficult to make assumptions here, since the citywide number of contractors subject to HCAO is unknown (this data is unavailable). A decline in employers paying the fee may also point to a decline in contractors and/or lease-holders subject to the HCAO.

- In FY2013-14, a total of 27 employers paid the fee (or a settlement) for a total amount of \$1,017,154.
- In FY2012-13, a total of 29 employers paid \$1,232,597.

- In FY2011-12, a total of 37 employers paid \$1,508,823.¹

B. The Minimum Standards Review Process

Starting in 2004, it has been standard practice for DPH to review the Minimum Standards through a stakeholder advisory process. It was that year that the Health Commission requested that OPP bring together organizations and individuals with interest in these matters to participate in the MS review process. This process is not required by, nor mentioned in, the Ordinance. But it has become standard practice to seek input from a group of stakeholders. Once every two years, DPH's Office of Policy and Planning (OPP) invite interested parties to serve on an HCAO Minimum Standards Work-Group. The group meets regularly for a set period of time with a goal to advise DPH on what, if any, revisions should be made to the Minimum Standards. Given the fast pace of changes in the health insurance marketplace, each HCAO Minimum Standards Work Group has agreed upon and requested adjustments to the Minimum Standards (rather than opt for status quo), and the Health Commission has accepted them. At the end of the two year cycle, the options available to employers are generally more limited than they were at the start of the two years.

i. The 2012 Minimum Standards review and the ACA

The Health Commission last acted to revise the Minimum Standards in 2012, through Resolution 12-11, "*Amending the Health Care Accountability Ordinance Minimum Standards.*" The effective date of these Minimum Standards was January 1, 2013. As was discussed at that time, the Affordable Care Act (ACA) brought a new wrinkle into the health insurance marketplace, adding new complexity to the process of reviewing and revising the Minimum Standards. When appropriate, the 2012 Minimum Standards integrated the ACA health reforms into the Minimum Standards. At that time, the changes were primarily protections for the insured (for example, the requirement that insurance plans may not require any copayment for preventive services).

Recognizing the fact that the ACA was meant to be more broadly implemented in January, 2014, the Work Group suggested that it would be best to reconvene in one year, rather than two, as required by the Ordinance. This was meant to ensure that the Minimum Standards would be aligned with the ACA in a timely manner. When the federal government delayed the ACA's employer mandate, DPH's Office of Policy and Planning, decided to return to the normal review schedule of once every two years. The ACA employer mandate, known as the Employer Shared Responsibility (ESR) requirement, is now meant to be effective on January 1, 2015 for

¹ This recalculation updates what was noted in the FY12 HCAO Minimum Standards report to the Health Commission. The number of employers previously reported was 56, with a total of \$1,502,904.

employers with 100 or more employees and in 2016 for employers with 50 to 100 employees. Small businesses will not be subject to the ESR. The ESR requires that employers:

- Offer affordable health coverage that provides a minimum level of coverage to their full-time employees (and their dependents); or
- The employer may be subject to paying an ESR payment.

The “minimum level of coverage” is defined by the ACA as a health insurance plan that, based on its actuarial value (AV), covers at least 60 percent of the costs (and the individual is responsible for the remaining 40%). These plans must also cover the ACA’s Essential Health Benefits (EHB), cover defined preventive services free of charge, and adhere to annual cost-sharing limits. A 60/40 plan translates to a Bronze-level metal tier plan in the ACA’s federal health insurance marketplaces. In addition to Bronze plans, the marketplace includes Silver (70%/30%), Gold (80%/20%), and Platinum (90%/10%). This means that the ACA’s Minimum Standards allow any plan that would be approved through Covered California.

ii. The 2014 Minimum Standards Work Group

The Work Group was reconvened in July 2014 to begin the review process for the 2015/2016 Minimum Standards. This group consisted of sixteen individuals who are interested in the HCAO, including employers/contractors, labor unions, brokers, and others. They were invited to participate based on several different factors. Some had a long history with the HCAO and the Minimum Standards Work Group; others showed interest after interacting with DPH and/or OLSE; others we have sought out in order to ensure that we have a range of voices represented in the process.

Of assistance to the group for information and analysis about the health insurance market were brokers from two different firms, Lynn Jones from NFP CA Insurance Services (formerly Levinson Benefits) and Simone Levy (Automatic Data Processing). These brokers provided information crucial to the process, answered the group’s questions, and provided insight on the many changes coming to the health insurance market. In light of health reform, this was especially useful to the Work Group. The brokers provided a broad base of knowledge, but were also specialists in the small business health insurance market.

The DPH participants are from the Office of Policy and Planning (OP&P), and did not participate in decision-making, and instead served in the following capacities:

- Meeting chair and facilitator: Frances Culp, Senior Health Program Planner
- Staff support: Leah Rosenbaum, 2015 OP&P Summer Intern
- Content expert - Affordable Care Act: Aneeka Chaudhry, Health Program Planner

Table #1: 2014 HCAO Minimum Standards Work Group Member List

Work-Group members were asked to attend all meetings and send only one member from

Name	Organization	Stakeholder Type
Lynn Jones	NFP CA Insurance Services/Levinson Benefits	Broker
Simone Levy	Automatic Data Processing	Broker
Bill Wong	San Francisco Airport	CCSF Rep
Donna Mandel	OLSE-Compliance	CCSF Rep
Aneeka Chaudhry	San Francisco Dept of Public Health	CCSF Rep
Frances Culp	San Francisco Dept of Public Health	CCSF Rep
Leah Rosenbaum	San Francisco Dept of Public Health	CCSF Rep
Angie Wong	RAMS	Employer Rep - Non-Profit
Danielle Bosetti	Enterprise Holdings	Employer Rep - Non-Profit
Debbi Lerman	Human Services Network	Employer Rep - Non-Profit
Frank Landin	Huckleberry Youth Programs	Employer Rep - Non-Profit
Mason Jeffrys	Dolores St Community Center	Employer Rep - Non-Profit
Ray Fort	Larkin Street Youth Services	Employer Rep - Non-Profit
Thomas Woo	Chinese Community Health Plan	Health Plan
Emma Gerould	SEIU 1021	Labor Union Rep
Tim Paulson	San Francisco Labor Council	Labor Union Rep
Josh Goodwin	SF Living Wage Coalition	Labor Rep
Karl Kramer	SF Living Wage Coalition	Labor Rep

each organization. The group was asked to make decisions using a consensus process, rather than voting. The schedule presented to the Work Group members consisted of four meetings throughout the month of July. Due to the need for additional educational time and challenges making some decisions, the Work Group added two meetings in August. The first meeting was held on July 11th and the last one was held on August 12th.

At the first Work-Group meeting, these goals were agreed upon:

1. To work with DPH's Office of Policy and Planning to develop recommendations related to the HCAO Minimum Standards;
2. The review and final recommendations will take into consideration the following:
 - a. **Affordability** for both employers and employees; and
 - b. Plan **availability**.

iii. Health Plan Review

In past years, the Work Group used the health insurance plan information from the small business market to make its decisions. The State defines a small business as having 2 to 50 employees for the purposes of health insurance. HCAO exempts for-profit businesses with 20

or fewer employees, and non-profit entities with 50 or fewer. The Work-Group uses this market to inform decisions for two reasons:

1. Small businesses must buy “off-the-shelf” insurance products, while larger businesses have the leverage to create their own. Even a small section of the whole set of small-business employers also required to comply with HCAO should be taken into consideration. If they cannot find affordable plans that meet the Minimum Standards, they will comply by paying the fee. It is a DPH priority to set up conditions by which insurance coverage is the best option.
2. These “off-the-shelf” plans are a good proxy to understand what is normal and available in the overall health insurance market. Everything that can be seen in the general insurance marketplace is reflected in the small business marketplace.

In past years, the Work Group reviewed between 20 and 40 small business health plans during their process. (In 2008, the group reviewed 26 plans.) Given the significant changes brought about by the ACA, this Work Group ended up reviewing 157 plans with premium costs. These premium costs were based on fictional employees ranging in ages. This included the following carriers, including the total number of plans:

- Aetna (33)
- Anthem Blue Cross (25)
- Blue Shield (14)
- California Choice Plans (33)²
- Health Net (22)
- Kaiser (14)
- United (16)

Small businesses in California can now access plans for their employees through the Small Business Health Options Program, or SHOP. As in the individual health insurance plan marketplace, Covered California, the SHOP plans follow the same metal tier structure and the AV requirements. There were 11 SHOP plans for review, including Blue Shield, Chinese Community Health Plan, and Kaiser Permanente.

² CaliforniaChoice is a TPA (Third Party Administrator) that offers several insurance companies (e.g., Kaiser) together to allow you and your employees the ability to select different plans of health coverage.

C. Recommendations: Revisions to the Minimum Standards

The current Minimum Standards now meet approximately one-quarter of the small business market, and are essentially set at the Platinum level of SHOP plans. As noted, the health insurance marketplace moves at a quick rate of change. This makes the Minimum Standards review and revision process a challenge each year. The financial burden on both the employers and the employees has been rising considerably. This year brought in new variables that introduced a level of complexity and confusion not experienced by this group before. This section will review the recommendations put forth by the MS Work-Group.

i. Recommendation#1: Align HCAO benefit requirements with the ACA’s Essential Health Benefits and Covered California benchmark plan.

To ensure a more consistent level of benefits, the Affordable Care Act (ACA) requires that insurance plans cover a package of diagnostic, preventive, and therapeutic services and products that have been defined as “essential” by the Department of Health and Human Services.

This package, commonly referred to as a set of essential health benefits (EHB) – constitutes a minimum set of benefits that the plans must cover. This list does not include the cost associated with these benefits; it is strictly related to which services are included in an ACA-compliant plan.

As you can see in Table #3, the services are those that most expect and many utilize: hospitalization, lab services, ambulatory patient services (i.e., an office visit), etc. The one benefit that has prompted the most questions is “habilitative services.” The federal government required states to define precisely what the term means and encompasses, and California’s definition is widely considered the most comprehensive: *“Habilitative services” means medically necessary health care services and devices that assist and individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health conditions, to the maximum extent*

Table #2

Essential Health Benefits
Ambulatory patient services
Emergency Services
Hospitalization
Maternity & Newborn Care
Mental health & substance use disorder services, including behavioral health
Prescription drugs
Rehabilitative & habilitative services
Laboratory Services
Preventive & wellness services & chronic disease management
Pediatric services, including oral & vision care

practical.³ Insurers may offer additional benefits. In each state, the details of the benefits are tied to a state benchmark plan. (In California, this plan is Kaiser’s 30 Small-Group HMO plan.)

The HCAO Minimum Standards cover a similar set of required benefits. The list of required MS benefits has not changed since they were first established in 2001-02. At that time, they were based primarily on Knox-Keene (HMO regulations) benefit requirements. Some required benefits were added by DPH and the Health Commission, including mental health and substance abuse treatment coverage. The Work-Group compared the ACA requirements to the MS. There were very few differences, and the differences that did exist were more related to choice of language than substance. The EHBs include the following terminology that the MS do not:

- Habilitative services;
- Wellness services; and
- Chronic disease management.

The ACA benchmark plan, the Kaiser 30 HMO plan, is accessible online and shows that its list of benefits is even more comprehensive than the full list of benefits for the Minimum Standards. This greater level of detail will provide DPH with additional information that can be used when employers have detailed coverage questions. DPH and the Work-Group fully agreed that the HCAO list of benefits should be modified to match the ACA list of required benefits.

- ii. [Recommendation #2: At the HCAO Minimum Standards Work-Group convening in two years, DPH will review the feasibility of dependent coverage.](#)

Several members of the Work-Group suggested that DPH develop a method to provide coverage for dependents. All were interested in this as a point of discussion. According to the Human Services Network (HSN), they first brought this to the attention of the Work-Group in 2008, but the suggestion was rejected at that time. There was a suggestion that in order to do this, the employees who wish to have dependent coverage should be required to pay some percentage of the monthly premium amount. The group members expressed concern that this is a complex issue that needs more time to review and discuss. To do justice to this issue, it will be given a priority for discussion when the group reconvenes in two years.

³ Policy Group, K. (2014, March 1). Benefit & Coverage Rules Under the ACA: California vs. Federal Provisions. Retrieved August 29, 2014.

- iii. Recommendation #3: The option for employers of using an employer-funded HSAs or HRAs may be used with a deductible or an OOP maximum that exceeds the allowable amount.

In 2012, the Health Commission accepted DPH's recommendation to reduce the \$4,000 maximum for the annual deductible to \$2,000. There was some concern at the time that employers may face difficulty accessing an affordable plan with a \$2,000 deductible. To increase the employer's options, HSA/HRAs were approved for use when an employer wished to secure a plan that met all of the MS except for a deductible exceeding \$2,000. For example, a business could secure an employer-funded plan-compatible HRA or HSA of \$500 for a plan with a \$2,500 deductible.

There was full consensus among the Work Group to expand the HSA/HRA option to the OOP maximum, and DPH recommends that this be allowed. As long as employees are never in a position to pay any amount over the MS maximums and the accounts are paid into by the employer only, this is a reasonable option to allow more flexibility.

- iv. Recommendation #4: Given the variability among the plans in each metal tier, the Minimum Standards should not be linked to one of the metal tier levels at this time.

The Work-Group studied the HCAO metal tiers and considered using one to define the maximum fee structure. While the metal tiers offer a standard list of maximum fees that a plan member would be required to pay, there is much room for variation within the plan's requirements due to the focus on Actuarial Value (AV). As noted on page 4, the plan's tier level is based on the percentage of cost-sharing between the health plan and the enrollee. So, for example, while the maximum office visit copayment allowed for a Gold level plan cannot exceed \$30 (the same as the current Minimum Standards), the OOP maximum can go as high as \$6,350. This is \$2,350 higher than the current Minimum Standards.

Choosing a tier would mean that something common like an office visit copay may be increased so that the OOP maximum can be lowered and still meet a certain AV. This could be a costly trade-off in terms of health outcomes if a copayment amount is higher than an individual could afford and care is delayed. In addition, choosing a tier means that almost all benefits have an associated maximum cost connected to it. The current MS were purposefully changed to require maximum amounts for the major items: OOP maximum, deductible, coinsurance, and office copay. Because different parties in the Work Group could not agree on which metal tier would be reasonable, this idea of tying the MS to one tier was quickly put to rest. Consensus could not be reached on this topic, so all agreed to keep the structure of the current Minimum Standards intact.

- v. Recommendation #5: Retain the majority of the MS requirements as they are now, with two adjustments: increase the OOP maximum and decrease the deductible.

Table #3 shows the recommendations for the Minimum Standards being made today. As you can see the two changes noted in Recommendation #5 are highlighted and include the following, which was the last agreement to be made among the Work-Group members.

OOP Maximum:

An Out-of-Pocket maximum, or OOP, is the maximum amount an insured individual will be required to pay in a year. Some plans exclude deductibles and other cost-sharing items from the OOP Maximum, making the reality of the cost-sharing burden higher for the insured. The HCAO Minimum Standards require that the OOP Maximum include all types of cost-sharing. It is recommended that this principle remain. However, DPH, in consultation with the Work-Group, concluded that the OOP Maximum should increase from \$4,000 to \$6,350.

This change is not insignificant, and some members of the Work-Group expressed discomfort with the increase. The reality is that there a large number and percentage of health plans using this number because of its prominence in the ACA metal tier plans. The ACA has set this \$6,350 as OOP maximum for three of the four metal tiers: Bronze, Silver, and Gold. (The OOP maximum for Platinum plans is \$4,000.) The OOP Maximum is one of the major variables to consider when establishing the AV for a plan. In 2010, the average out-of-pocket expense for a California household with employment-based insurance was \$1,298, and it was even lower for San Francisco households at \$1,166⁴. It is relatively unusual for anyone to have health care costs that bring them to the OOP maximum, regardless of the amount. Even at the increased rate, it is a very important protection for those individuals that do suffer a catastrophic accident or illness that can easily cost hundreds of thousands of dollars.

Deductible:

The deductible is the amount a person pays in a calendar year before the health plan begins to cover services, at which time the insured individual pays just the plan's defined cost-sharing amount for each service. The Work Group reviewed six different options with all plan variables the same (current minimum standards with the \$6,350 OOP max). While larger employers are still not requiring deductibles of their employee plans, more than half (59%) of the smaller

⁴ Gabel, J., Lore, R., McDevitt, R., & Pickreign, J. (2012, April 1). Health Insurance Reforms: How Will They Affect Employment-Based Coverage in California? Retrieved August 29, 2014, from http://laborcenter.berkeley.edu/pdf/2012/health_insurance_reforms12.pdf

businesses in California required a deductible⁵. The decrease in the amount of the deductible for the 2015-16 Minimum Standards will help the employee access their covered health services sooner, and soften the impact of the increase in the OOP maximum. Of course, it is important to note that the Minimum Standards are just that, a minimum. Employers may offer better benefits, and in the case of the deductible and OOP, they can also use an HSA or HRA to fill a gap in their plan and these requirements.

Table #3: Recommendations to Update the Minimum Standards

Benefit Requirement	Current Minimum Standards	Recommended Minimum Standards
Premium Contribution	Employer: 100% Employee: Zero	NO CHANGE
Annual Out-of-Pocket (OOP) Max	In-Network: \$4,000 max. Out-of-Network: Not specified <i>Must include all types of cost-sharing (deductible, copays, co-insurance, etc.)</i>	In-Network: \$6,350 Out-of-Network: Not specified <i>1) Must include all types of cost-sharing (deductible, copays, co-insurance, etc.)</i> <i>2) Employer may offer a plan with a higher deductible only if they combine it with a fully-funded HSA or HRA.</i>
Medical Services Deductible	In-Network: \$2,000 max. Out-of-Network: Not specified <i>Employer may offer a plan with a higher deductible only if they combine it with a fully-funded HSA or HRA.</i>	In-Network: \$1,500 max. Out-of-Network: Not specified <i>Employer may offer a plan with a higher deductible only if they combine it with a fully-funded HSA or HRA.</i>
Prescription Drug Deductible	In-Network: \$300 max. Out-of-Network: Not specified	NO CHANGE
Prescription Drug Coverage	Must provide prescription drug coverage, including coverage of name-brand drugs.	NO CHANGE
Co-insurance	In-Network: 80%/20% Out-of-Network: 50%/50%	NO CHANGE
Preventive Care	In-Network: Provided at no cost. Out-of-Network: Subject to the plan's out-of-network requirements.	NO CHANGE

⁵ See previous footnote.

Benefit Requirement	Current Minimum Standards	Recommended Minimum Standards
Co-pay for PCP visits	In-Network: \$30 max Out-of-Network: Not specified	NO CHANGE
Other required services	Services on this list must be covered. When coinsurance is applied: In-Network: 80%/20% Out-of-Network: 50%/50% List based on Minimum Standards list.	Services on this list must be covered. When coinsurance is applied: In-Network: 80%/20% Out-of-Network: 50%/50% List based on EHBs and Covered California benchmark plan.
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.	NO CHANGE

Many options for change to the Minimum Standards were explored by the group. This solution takes the needs of employers and employees into consideration. The Work-Group reviewed 157 small business plans available on the regular small business market and Covered California/SHOP. While only 24 percent are compliant with the current standards, the recommendations noted above double this to 48 percent. An analysis of the premiums associated with these plans shows that the average monthly cost is \$656, which is close to the monthly fee maximum of \$680 paid by employers subject to HCAO who do not provide health insurance that meets the MS.

In these early days of the ACA, it is difficult to anticipate what will happen in the health insurance marketplace, even in the near future. DPH wishes to avoid a situation where, in two years, employers have very few health plans from which to choose. As noted previously, DPH has an interest in seeing employers comply with the HCAO by offering health insurance that meets the Minimum Standards. Therefore, in one year, DPH will conduct a review of the plans on the small business marketplace as compared to the Minimum Standards. If the percentage of plans meeting the MS is lower than 40 percent, DPH will undertake a full re-examination of the MS and develop interim recommendations for the Health Commission to consider.

D. Conclusion

In conclusion, DPH fully supports the HCAO and has a strong interest in seeing the Ordinance meet its objective of reducing the numbers of uninsured and thereby enhancing the quality,

stability, health, and productivity of the workforce on the City's contracts and leases. The ACA has brought about many changes in the health insurance market, with many protections for the insured. This year, however, the MS review was made more complicated than past years because of the significant changes newly brought to the small business health insurance marketplace. While the Covered California SHOP plans appeal at this time to only a small percentage of the small businesses statewide, and there was no interest this year in connecting the Minimum Standards to a tier level, the ACA/Covered California has had a strong influence on health plan design and corresponding costs.

The draft resolution requests approval to revise the Minimum Standards effective January 1, 2015. With these recommendations in action, the MS will be aligned with ACA's Essential Health Benefits; evaluate dependent coverage at the next full Minimum Standards review; increase the OOP maximum amount to \$6,350, while decreasing the deductible to \$1,500. These new Standards are strong from the perspective of DPH and meet the goals set for and represent advice received from the HCAO Minimum Standards Work Group. Even with the volatility in the health insurance marketplace, these recommendations focus on a minimal amount of change to the Minimum Standards and provide a balance in the consideration of employer and employee needs.