Health Commission
City and County of San Francisco
Resolution No. 21-10

AMENDING THE HEALTHCARE ACCOUNTABILITY ORDINANCE MINIMUM STANDARDS

WHEREAS, On May 29, 2001, the Board of Supervisors passed the Healthcare Accountability Ordinance (HCAO), requiring that employers doing business with the City provide health insurance coverage for their employees or pay a fee to offset costs for health care provided by the City and County of San Francisco to the uninsured; and

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

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

WHEREAS, In September 2010, DPH convened the Minimum Standards Work-Group, with representatives from various entities including health insurance broker firms, employers, advocates, and others, with the task of making recommendations for a revised set of Minimum Standards; and

WHEREAS, This Work-Group met four times and the majority agreed to certain revisions, as detailed herein, that would balance the needs of employers and employees, by making it a goal to increase the health insurance plan options for employers, retain comprehensive benefits for employees, and consider affordability for both; and

WHEREAS, With the help of the Work-Group's guidance, DPH produced a written report to be presented to the Health Commission on December 7, 2010, with an explanation of the process and description of the recommendations; and

WHEREAS, DPH supports the proposals developed by the HCAO stakeholders group, as described fully in an attachment to this resolution, and is respectfully requesting approval from the Health Commission; THEREFORE, BE IT

RESOLVED, The revised Minimum Standards will allow for any type of plan to be acceptable, rather than just an HMO as the Minimum Standards stipulated in the past; and be it

FURTHER RESOLVED, The maximum annual out-of-pocket amount for which the plan enrollee is responsible may not exceed $4,000, including deductibles of any kind, copayments, and coinsurance for in-network services; and be it

FURTHER RESOLVED, Coinsurance is set at a maximum enrollee contribution of 20 percent for in-network services and 50 percent for out-of-network services; and be it

FURTHER RESOLVED, The plan must follow the new health reform provision effective on September 23, 2010, requiring the coverage of emergency room and ambulance services at in-network cost-sharing amounts, regardless of the facility, with no exception for grandfathered plans; and be it

FURTHER RESOLVED, The plan must follow the new health reform provision requiring preventive care-related visits and services with no enrollee cost-sharing, with no exception for grandfathered plans; and be it

FURTHER RESOLVED, Certain benefit requirements in the 2008 Minimum Standards will remain the same, as follows: list of covered services; no specified copayment amount for covered services; no specified copayment amount for prescription drugs; and maximum of $30 copayment for non-preventive care primary care visits and maternity-related visits; and be it

FURTHER RESOLVED, Effective January 1, 2011, that the Health Commission approves the revised Minimum Standards, as detailed in Attachment 1 to this resolution.

(Attachment 1)

Health Care Accountability Ordinance:

Recommendations for New Minimum Standards

#	Benefit Requirements	Current Min. Standards ('08)	Recommendations (2010)
1	Type of Plan Required	The plan that meets these standards must be an HMO.	Any type of plan that meets the Minimum Standards as described below.
2	Employee Premium Contribution	The employer must pay 100% of the employee's health coverage premium.	The employer must pay 100% of the employee's health coverage premium.
3	Annual Out-of-Pocket (OOP) Maximum	No higher than a $3,500 maximum, which may include a prescription drug deductible.	In-Network: No higher than a $4,000 maximum, when added to the medical &/or pharmaceutical deductible (if the plan includes one or both). Out-of-Network: Not specified. OOP maximum has to include any employee cost-sharing in the plan (deductible, copayments, coinsurance, etc.).
4	Prescription Drug Deductible	Allowed, but may not exceed $3,500 when added to the plan's OOP maximum.	In-Network: No higher than a $4,000 maximum, when added to the medical &/or pharmaceutical deductible (if the plan includes one or both). Out-of-Network: Not specified.

#	Benefit Requirements	Current Min. Standards ('08)	Recommendations (2010)
5	Regular (Medical Services) Deductible	Not allowed.	In-Network: No higher than a $4,000 maximum, when added to the medical &/or pharmaceutical deductible (if the plan includes one or both). Out-of-Network: Not specified.
6	Prescription Drug Copayments	Not specified.	Not specified. Coverage of non-formulary drugs not required.
7	Coinsurance Percentages	Not specified.	20% in-network 50% out-of-network
8	Copay for Preventive Care Visits & Services[1]	$30 maximum.	In-Network services are not subject to a deductible, copay, or coinsurance (per health reform rules). Preventive care services from an out-of-network provider are subject to the plans out-of-network requirements.
9	Copayments for Physician Office Visits for Primary Care, Perinatal/Maternity	$30 maximum.	$30 maximum. Out-of-Network: Not specified.
10	Services: • Hospital inpatient, physician & hospital service • Rehabilitative therapies, outpatient and inpatient • Outpatient services and procedures • Surgery & anesthesia • Organ transplants • Cancer clinical trials • Outpatient diagnostic services (x-ray, labs, etc.) • Perinatal and maternity care, including delivery	These services must be covered, but a copayment amount is not specified.	These services must be covered. When coinsurance is applied to services: 20% in-network 50% out-of-network When copayments are applied for these services: Not specified.

[1] Applies to plans beginning on 9/23/2010 and after: non-grandfathered plans must provide coverage for certain preventive items and services with no cost-sharing allowed.

#	Benefit Requirements	Current Min. Standards ('08)	Recommendations (2010)
	services and postpartum care • Physical, Occupational, and Speech Therapy • Skilled nursing services • Home health services • Durable medical equipment • Hospice care		
11	Mental Health Services ♦ Inpatient & Outpatient Alcohol & Substance Abuse Services ♦ Inpatient & Outpatient	These services must be covered, but a copayment amount is not specified.	These services must be covered. When coinsurance is applied to services: 20% in-network 50% out-of-network When copayments are applied for these services: Not specified
13	Emergency Room Services & Ambulance[2]	These services must be covered, but a copayment amount is not specified.	Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.

I hereby certify that the San Francisco Health Commission at its meeting of December 7, 2010 adopted the foregoing resolution.

Mark Morewitz
Executive Secretary to the Health Commission

[2] Applies to plans beginning on 9/23/2010 and after: non-grandfathered plans must cover Emergency Services at in-network rates regardless of the provider and without prior authorization.