Health Commission
City and County of San Francisco
Resolution No. 18-2

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
9. 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. 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.
10. 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. 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.
11. Hospitalization	• 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	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified
13. Rehabilitative & Habilitative Services	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified
14. Laboratory Services	• 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 17, 2018.

Mark Morewitz, MSW
Health Commission Executive Secretary

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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	• 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 OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.).
3. Medical Deductible	• In-Network: $2,000 • Out-of-Network: Not specified 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.
4. Prescription Drug Deductible	• 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	• In-Network: 80%/20% • Out-of-Network: 50%/50%
7. Copayment for Primary Care Provider Visits	• In-Network: $45 per visit. • Out-of-Network: Not specified
8. Ambulatory Patient Services (Outpatient Care)	• 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

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