Health Commission
City and County of San Francisco
Resolution No. 22-16

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 May 2022, 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, Taking into consideration the workgroup's recommendations, DPH produced a written report to be presented to the full Health Commission on July 19th, 2022 with an explanation of the process and description of the recommendations; and

WHEREAS, A review of the current Minimum Standards against 165 plans on the small business market in 2022 found that only 5 percent of silver plans are compliant; with the changes recommended here, this increases the share of compliant silver plans to 75 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 2023 and 2024:

Benefit Requirement	New Minimum Standard
Type of Plan	Any type of plan that meets all the Minimum Standards as described below. All gold- and platinum-level plans written in California are deemed compliant if: • the employer covers 100 percent of both the plan premium and medical services deducible; and • the plan covers all required covered services standards (5, 8-16) Employers may use any health savings/reimbursement product that supports coverage of the medical deductible.
1. Premium Contribution	Employer pays 100 percent
2. Annual OOP Maximum	In-Network: • **Employer must cover in-network out-of-pocket expenses up to 50 percent of plan's annual out of pocket maximum. These expenses must be covered on a first-dollar basis.** • Employers may use any health savings or reimbursement product that supports compliance with this minimum standard. • OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.). • *The plan's out of pocket maximum cannot exceed the California Patient-Centered Benefit Design* Out-of-Pocket limit for a silver coinsurance or copay plan during the plan's effective date. In 2023, the limit is $8,750 Out-of-Network: Not specified
3. Medical Deductible	• In-Network: $3,000 • Out-of-Network: Not specified
4. Prescription Drug Deductible	• In-Network: $300 • 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: 60 percent/40 percent • Out-of-Network: 50 percent/50 percent
7. Copayment for Primary Care Provider Visits	• In-Network: $60 per visit. When coinsurance is applied See Benefit Requirement #6 • Out-of-Network: Not specified
8. 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.
9. 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.
10. 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
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 19, 2022.

Mark Morewitz, MSW
Health Commission Executive Secretary