City and County of San Francisco
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# M E M O R A N D U M

June 15, 2026

**To:** Laurie Green, MD, President, and Members of the Health Commission

**Through:** Daniel Tsai, Director of Health
Naveena Bobba, MD, Deputy Director of Health

**Through:** Sneha Patil, Director, Office Policy and Planning

**From:** Max Gara, Senior Health Program Planner, Office of Policy and Planning
Sarah Neukrug, Health Program Planner, Office of Policy and Planning

**Re:** Health Care Accountability Ordinance – Suggested Revisions to the Minimum Standards for 2027 and 2028

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As required by the San Francisco Health Care Accountability Ordinance (HCAO), the Department of Public Health (DPH) has recently undertaken a thorough biannual review of the current HCAO Minimum Standards in relation to the current health care insurance market in California. Employers subject to the HCAO must offer their employees a health plan that meets or exceeds all these Minimum Standards. The attached report (Attachment A) describes the findings and recommendations based on the feedback by the HCAO Minimum Standards Workgroup convened by DPH (Attachment C).

We respectfully request that you consider the recommendations, summarized in Attachment B to this report, and look forward to discussing the findings with the members of the Health Commission on June 15, 2026. We have also attached a draft resolution (Attachment D) for your consideration which would update the Standards for the first of the new calendar 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 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 including at the San Francisco Airport (SFO), or the San Bruno Jail. For FY26-27, the fee is $8.00 per hour worked per employee up to $320 per week for each employee.[1]

## II. Healthcare Cost Impacts and Trends

The following section provides an overview of the current health insurance landscape and trends over the previous several years. This information helped to inform the development of the recommendations for HCAO Minimum Standards and provides financial context for both employees and employers navigating the health insurance market.

### A. Healthcare Trends

Expenditures are expected to continue rising for all parties in the health care system. Consider the following findings:

***Healthcare expenditures continue to rise.*** According to the Center for Medicare and Medicaid Services (CMS), national healthcare expenditures grew 7.2% to $5.3 trillion in 2024 or $15,474 per person. CMS

[1] Office of Labor Standards & Enforcement (2026). Retrieved from https://www.sf.gov/information/health-care-accountability-ordinance

projects that over 2024-2031, average growth in national healthcare expenditures (5.8 percent) is projected to outpace that of average GDP growth (4.3 percent) resulting in an increase in the health spending share of GDP from 17.6 percent in 2023 to 20.3 percent in 2031.[2]. Health spending was $4.9 trillion in 2023 and is projected to reach $8.6 trillion in 2033. Between 2010 and 2020, health care spending in California grew faster on an annual average basis than health spending in the U.S. and the economic growth in the state.[3]

***Premium and out-of-pocket medical expenses continue to rise and contribute to affordability concerns.*** The average annual single premium and the average annual family premium each increased by 6% since 2024.[4] Comparatively, there was an increase of 5.2% in workers' wages while inflation rose by 5.8%. Over the previous five years, the average premium for family coverage has increased by 22% compared to an 27% increase in workers' wages and 21% inflation.[5] The average deductible amount in 2025 for workers with single coverage and a general annual deductible is $1,866. Among workers with single coverage and any deductible, the average deductible amount has increased 17% over the last five years and 43% over the last ten years.[6]

The observed rise in healthcare costs is contributing to significant affordability concerns. Out-of-pocket costs such as deductibles, coinsurance, and copayments for medical services and prescriptions can accumulate to unaffordable amounts. About four in ten insured adults worry about affording their monthly health insurance premium, and 48% worry about affording their deductible before health insurance kicks in. In California, nearly two out of three are worried about unexpected medical bills and out-of-pocket costs, and about one in four Californians (27%) say they or someone in their family had problems paying at least one medical bill in the past 12 months.[7] There are disproportionalities in these impacts, with Latino/x Californians most likely to experience problems paying for medical bills (40%), followed by people who are Black (36%), White (20%), or Asian (17%). Californians with lower incomes are more than twice as likely to report having problems paying medical bills compared to Californians with higher incomes (44% compared to 21%).[8]

## B. Upcoming Policy Changes Impacting Health Coverage

***Federal Changes: ACA Subsidies Expiration.*** The enhanced ACA premium tax credits initially passed as part of the 2021 American Rescue Plan Act expired at the end of 2025. These enhanced tax credits reduced the maximum amount eligible ACA enrollees had to contribute towards premiums, and extended eligibility to people with incomes over 400 percent of FPL, leading to a surge in ACA enrollment nationally and in California.[9] Covered CA estimates that 1.7 million Covered CA enrollees will see an average net premium increase of 66 percent without the enhanced subsidies, pricing many enrollees out of the Marketplace altogether.[10]

[2] CMS, NHE Fact Sheet, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet; CMS (2026)
[3] Wilson et al. (2023), 2023 Edition – California Health Care Spending, CHCF, https://www.chcf.org/resource/california-health-care-spending-almanac/
[4] KFF, 2025 Employer Health Benefits Survey, https://www.kff.org/report-section/ehbs-2023-summary-of-findings/
[5] KFF, 2023 Employer Health Benefits Survey, https://www.kff.org/report-section/ehbs-2023-summary-of-findings/
[6] KFF, 2025 Employer Health Benefits Survey, https://www.kff.org/health-costs/2025-employer-health-benefits-survey/#55d346a7-5bff-4d99-840c-a793b6a03320
[7] Bailey, L. R., Catterson, R., Alvarez, E., & Noble, S. (2023, February 16). The 2023 CHCF California Health Policy Survey. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf
[8] Bailey, L. R., Catterson, R., Alvarez, E., & Noble, S. (2023, February 16). The 2023 CHCF California Health Policy Survey. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf
[9] Covered California, Impacts of the Enhanced Premium Tax Credits in California, https://www.coveredca.com/pdfs/congressionalfact-sheet922025.pdf
[10] Covered California News Release, August 2025, 08-14-25-COVEREDCA-PY26-Rates Final.pdf

## III: The HCAO Minimum Standards Review Process

The Health Commission has the sole authority to set the Minimum Standards. The last revision occurred in 2024 and went into effect on January 1, 2025. Since 2004, DPH has convened a workgroup of stakeholders representing non-profit and for-profit employers, labor advocates, health insurance brokers, and city departments to contribute their expertise and experiences to this process.

> "[Health plans offered by Covered Employers to comply with the HCAO must…] meet minimum standards **prepared by the Health Director and approved by the Health Commission**. The minimum standards shall provide for a maximum period for each Covered Employee's health benefits to become effective, no later than the first of the month that begins after 30 days from the start of employment on a covered Contract, Subcontract, Lease, or Sublease. 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 develop recommendations to revise the Minimum Standards that will offer 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. The recommended revisions to the Minimum Standards were selected to ensure that the plan premium and 50% of employees' out-of-pocket expenses are covered by the employer in return for employers having access to a greater number of affordable silver 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.

When developing the Minimum Standards, one of the central objectives of 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. It is important that both employers and employees have affordable plans to choose from.

### A. The 2026 HCAO Workgroup

The HCAO workgroup met two times: first on April 28, 2026, and again on May 14, 2026. Maxwell Gara, with the Office of Policy & Planning (OPP), chaired the workgroup. 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. A list of the workgroup's membership can be found in Attachment C. All members of the workgroup reviewed the recommendations in this report.

### B. Health Plan Review

The workgroup evaluated 137 small group health plans from Q2 2026 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 plans, 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 healthy number of plans available in the small business market.

**TABLE 1: Summary of Plans Analyzed by 2026 Workgroup**

| Carrier | Bronze | Silver | Gold | Platinum | Total |
|---|---|---|---|---|---|
| Aetna | 2 | 0 | 4 | 1 | 7 |
| Anthem Blue Cross | 5 | 10 | 3 | 5 | 23 |
| Balance by Chinese Community Health Plan | 2 | 2 | 1 | 4 | 9 |
| Blue Shield | 8 | 8 | 1 | 5 | 22 |
| Health Net | 2 | 4 | 5 | 7 | 18 |
| Kaiser | 6 | 11 | 9 | 9 | 35 |
| Sutter Health Plan | 4 | 0 | 4 | 2 | 10 |
| United Healthcare | 0 | 0 | 2 | 2 | 4 |
| **Total** | **31** | **36** | **31** | **39** | **137** |

## IV: Minimum Standard Recommendations

To be compliant with the HCAO, a covered employer must offer the employee a plan that meets or exceeds all the Minimum Standards. The workgroup reviewed a range of small group plans across carriers, and generally found that gold-, platinum-, and about half of silver-level plans on the marketplace are compliant with the current Minimum Standards. Based on the analysis of the 2026 small group health plans, only 56% of the 36 silver plans complied with the Minimum Standards. This was down from 77% in 2024 when the Standards were initially approved by the Health Commission.

With interest in ensuring a high number of compliant silver plans are available to employers to choose from while minimizing the negative impact of increasingly high out-of-pocket costs on workers, the workgroup analyzed variations on the standards against the small group plans. Based on this review and analysis, the following recommendations are made for the current Minimum Standards:

**Recommendations**:

- Continue to allow all gold and platinum level plans to be deemed automatically compliant if the employer fully covers the plan premium and medical deductible.
- Maintain **100% premium coverage for employees**
- Maintain requirement for **employer coverage of 50% OOP expenses for employees.**
- Require plans **cover essential health services** such as pre/post natal care, emergency/ hospital services, etc. (i.e., Stds #5, 8-16).
- Retain the framework that ensures wide availability of compliant silver plans. Under this framework:
    - Employers are required to cover up to 50% of the plan's out-of-pocket limit;
    - Cost sharing (e.g. medical and prescription drug deductibles) limits are adjusted to allow for a significant increase in silver plan availability.

Overall, workgroup members came to consensus agreement on all 16 Minimum Standards. Attachment B provides a side-by-side comparison of the current Standards that were adopted in 2024 and recommendations from the 2026 workgroup. 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, the average annual health insurance premium in California in 2025,

including the employer contribution, was $10,033 for single coverage and $28,397 for family coverage, a 7% increase from the previous year.[11] Nationally, annual premiums for have increased 26% over the past five years, and 53% over the last ten years. 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.

**Recommendation**: Retain current Minimum Standard.

***Minimum Standard 2: Annual Out-of-Pocket (OOP) Maximum***

- ***In-Network:*** Employers must cover out-of-pocket (OOP) expenses up to 50% of the plan's 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 is synced to the Federal out-of-pocket limit for a self-only coverage plan.
- ***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 workgroup agreed to retain the framework that the 2022 and 2024 workgroups used to increase the availability of silver plans. Under the framework, employers must cover employee in-network OOP medical expenses up to 50% of the plan's out-of-pocket maximum, while the cost-sharing standards (e.g., prescription drug and medical deductibles) are increased, which will expand the number of compliant plans. The expenses must be covered on a first dollar basis, and employers can use any health savings or reimbursement product that supports compliance with this minimum standard. For example, if a plan's OOP max is $8,000, then the employer must cover the initial $4,000 of expenditures that count towards the OOP max.

To maintain plan availability, the workgroup agreed that the OOP maximum should remain synced to the Federal out-of-pocket limit for a self-only coverage plan. Syncing the OOP max to a benchmark provides greater predictability for employers to anticipate and prepare for subsequent plan years. In 2027, the limit will be set to $12,000. Under this benchmark, employers will be responsible for up to $6,000 of employee OOP expenses if they choose a silver plan with the maximum OOP limit, up from $4,800, or an additional $1,200 from the current limit.

Based on this cost responsibility for employers, the group recommended adjusting the medical deductible to $3,200 max and the prescription drug deductible to $500 max. The rationales for these recommendations are discussed in greater detail in their respective Minimum Standard sections. Adjusting the Standards as described would increase the percentage of compliant silver plans available on the small group market from 56% to 72%. This compliance rate is comparable to when the Standards were previously revised in 2024 (77%) and 2022 (75%). Employer representatives emphasized that, despite the increases in their cost responsibility, the greater availability in silver plans is highly desirable and allows for more flexibility to tailor health plans to their staff makeup and needs. Labor representatives, while supportive of expanding plan availability in return for employers covering a proportion of OOP expenses, voiced some concern

[11] Kaiser Family Foundation, 2025 Employer Health Benefits Survey. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/#b80a5be7-6ddd-4d81-b9af-3126336155ca

regarding the proportion of silver plans that should be compliant when revising the standards.

Lastly, members specified that there should be messaging and educational materials for both employers and employees on the OOP requirements and how to comply with the standard. They specifically requested more information be provided on different “employer-funded” mechanism, such as a pre-paid debt cards, that employees can use for covering OOP costs. Workgroup members cited copay reimbursement as particularly challenging for employees living paycheck to paycheck and wanting to ensure these costs were paid upfront when possible. DPH will continue to work with OLSE to communicate the Standards with employers and employees and explore additional options for compliance.

**Recommendation**: Retain current Minimum Standard.

***Minimum Standard 3: Medical Services Deductible***

- ***In-Network:*** *No higher than a $3,000 maximum.*
- ***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. The workgroup found that the medical deductible impacts availability of silver plans. Of plans analyzed, 81% of silver plans had a medical deductible of $3,000 or less, down from 97% when plans were analyzed in 2024.

Adjusting the medical services deductible maximum to $3,200 for in-network services would, in tandem with the increases to the prescription drug deductible maximum, increase the availability of compliant silver plans from 56% to 72% based on the available Q2 2026 small group plans. The Minimum Standards need to last for two years and should ensure there are enough plans available from a diverse array of carriers during the entirety of this period. While concerns were raised that increasing the deductible could burden employees, there was recognition that employers' contributions under the OOP standard would cover the deductible increases.

**Recommendation**: Revise Minimum Standard as follows:

- ***In-Network:*** *No higher than a $3,200 deductible.*
- ***Out-of-Network:*** *Not specified.*

***Minimum Standard 4: Prescription Drug Deductible***

- ***In-Network:*** *No higher than a $400 deductible.*
- ***Out-of-Network:*** *Not specified.*

Prescription drug spending surged in 2025, rising 12.7% to $915 billion in 2025, one of the fastest growth rates in the past two decades.[12-13] The historic increase was driven by growth in GLP-1 weight-loss medications. Looking forward, from 2026–27, average growth is projected to slow to 5.6 percent due to decreasing ACA Marketplace enrollment and slower anti-obesity medication uptake. For 2028–33, growth is projected to average 4.7 percent, with Medicare (4.3 percent) and out-of-pocket spending (4.1 percent) growth also slowing.[14] 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. The workgroup found that the $400 maximum limits the availability of silver plans and reached consensus to change the standard

[12] National trends in prescription drug expenditures and projections for 2026, American Journal of Health System Pharmacy, 2025 Apr 30. Accessed at https://pubmed.ncbi.nlm.nih.gov/42059345/

[13] Center for Medicare and Medicaid Services, NHE Fact Sheet, Retrieved from https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

[14] Center for Medicare and Medicaid Services (2024), National Health Expenditure Projections 2024-2033 Forecast Summary. Retrieved from https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf

and increase the maximum to $500. While concerns were raised that increasing the deductible could overly burden employees, there was recognition that employers' increased contributions under the OOP standard would help to cover the deductible increases.

**Recommendation**: Revise Minimum Standard as follows:
- ***In-Network:*** *No higher than a $500 deductible.*
- ***Out-of-Network:*** *Not specified.*

***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 2025, a large majority of covered workers (92%) are in a plan with tiered cost sharing for prescription drugs.[15] Cost-sharing tiers generally refer to a health plan placing a drug on a formulary or preferred drug list that classifies drugs into categories that are subject to different cost sharing or management. Often, there are different tiers for generic, preferred and non-preferred drugs. 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 current Minimum Standard.

***Minimum Standard 6: Coinsurance Percentages***
- ***In-Network: 5****5% / 45%*
- ***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.

[15] Kaiser Family Foundation. *2025 Employer Health Benefits Survey*. 2025. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/.

The workgroup evaluated maintaining the standard at 55%/45% and found that that current limit was not a limiting factor in the availability of compliant health plans. Overall, 96% of the available Q2 2026 small group plans complied with these coinsurance rates. Given that the coinsurance rate requirements were not a limiting factor in plan availability, and to prevent cost increases to employees, the consensus recommendation is to retain the current Minimum Standard.

**Recommendation**: Retain current Minimum Standard.

***Minimum Standard 7: Copayment for Primary Care Provider Visits***
- ***In-Network:*** *$65 per visit.* When coinsurance is applied See Benefit Requirement #6
- ***Out-of-Network:*** *Not specified*

A copayment is a fixed amount the consumer pays for a covered healthcare service after the deductible is met. In the analysis of health plans, 81% of silver plans had a copay of $65 or less, down from 92% when plans were analyzed in 2024. Workgroup members expressed a strong desire to limit changes to the copay under the standard. While the current copay limit has some impact on plan availability, the consensus recommendation is to retain the current Minimum Standard to prevent cost increases to employees.

**Recommendation**: Retain current Minimum Standard.

***Minimum Standards 8-16***

8. ***Preventive & Wellness Services***
9. ***Pre/Post-Natal Care***
10. ***Ambulatory Patient Services (Outpatient Care)***
11. ***Hospitalization***

12. ***Mental Health & Substance Use Disorder Services, Including Behavioral Health***
13. ***Rehabilitative & Habilitative Services***
14. ***Laboratory Services***
15. ***Emergency Room Services & Ambulance***
16. ***Other Services***

The workgroup reached consensus in deciding to maintain these Minimum Standards. When coinsurance is applied, see Standard #6. When copayments are applied for Primary Care Provider Services, see Standard #7.

**Recommendation**: Retain current Minimum Standards.

## IV: Other Items

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

### A. Financial Pressures on Non-Profits Organizations and Employees

Workgroup members raised serious concerns that rising healthcare costs have created a difficult financial situation for both employers and employees, especially those in the non-profit sector. While members agreed that it is a priority to keep healthcare costs as low as possible for employees, they also understand that employers need adequate funding to provide affordable healthcare benefits for their employees. Workgroup members expressed concern that these rising costs are compounded by the City's proposed budget cuts to nonprofit organizations. Members noted that cost-of-doing-business adjustments for City contracted nonprofits are not keeping pace with inflation nor with rising business, healthcare, or living costs. It was noted that these forces are collectively contributing to profound pressures to the city's non-profit sector and creates significant challenges for organizations to provide affordable and comprehensive health coverage to their employees, ensure employees receive livable wages, and retain staff.

### B. Future Workgroups Cycles

For future workgroup cycles, members requested additional viewpoint diversity in participants (e.g. organizations with different budget and staffing sizes, etc.) to better understand potential implications from proposed revisions to the Minimum Standards. There were also requests to provide more data on the financial impact on employers and employees from changes in the Standards. Currently this data is not readily available, and a methodology and process would need to be developed to collect and analyze the information. The Department will explore how to incorporate more diverse perspectives in future cycles and how to potentially collect financial impact data from HCAO covered employers so it can be used to inform future revisions of the Standards.

## V: Conclusion

DPH continues to support the HCAO and maintains its commitment to 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 HCAO Workgroup came to consensus on all 16 Minimum Standards. With the recommendations outlined in this report, the Minimum Standards will:

- Continue to allow all gold- and platinum-level plans automatic compliance if premium and deductible fully covered;
- Retain a framework that provides significant availability of silver plans while reducing the overall cost responsibility for employees. Under this framework:
  - Employers cover out-of-pocket expenses up to 50% of the plan's Out-of-Pocket Maximum;
  - Medical Deductible revised to $3,200 max;

| | |
|---|---|
| ○ Prescription Drug Deductible revised to $500 max | 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, 2027. |

## Recommendations for New Minimum Standards, 2027-2028

The following summarizes the workgroup's review and recommendations for the Minimum Standards effective January 1, 2027 through December 31, 2028. A health plan must meet all 16 Minimum Standards to be deemed compliant.

| Benefit Requirement | Current Minimum Standard (2025-26) | Recommended Revision (2027-28) |
|---|---|---|
| **Type of Plan** | Any type of plan that meets the Minimum Standards as described below.<br><br>All gold- and platinum-level plans are deemed compliant if the employer funding requirements and coverage for required services described below are satisfied. | **Recommendation:** Retain current Minimum Standard. |
| **1. Premium Contribution** | Employer pays 100%. | **Recommendation:** Retain current Minimum Standard. |
| **2. Annual Out-of-Pocket Maximum** | • ***In-Network**:*<br>○ 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.<br>○ Employers may use any health savings or reimbursement product that supports compliance with this minimum standard.<br>○ OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.).<br>○ *The plan's out of pocket maximum cannot exceed* the Federal out-of-pocket limit for a self-only coverage plan during the plan's effective date.<br>• ***Out-of-Network**: Not specified* | **Recommendation**: Retain current Minimum Standard. |
| **3. Regular (Medical Services) Deductible** | • ***In-Network**: $3,000 max.*<br>• ***Out-of-Network**: Not specified* | **Recommendation**: Revise Minimum Standard to set the In-Network Medical Services deductible to $3,200 max. |
| **4. Prescription Drug Deductible** | • ***In-Network**: $400 max.*<br>• ***Out-of-Network**: Not specified* | **Recommendation:**<br>• Revise Minimum Standard to set the In-Network Prescription Drug Deductible at $500 max. |

| Benefit Requirement | Current Minimum Standard (2025-26) | Recommended Revision (2027-28) |
|---|---|---|
| **5. Prescription Drug Coverage** | *Plan must provide drug coverage, including coverage of brand-name drugs.* | **Recommendation:** Retain current Minimum Standard. |
| **6. Coinsurance Percentages** | • ***In-Network***: 55%/45%<br>• ***Out-of-Network***: *50%/50%* | **Recommendation:** Retain current Minimum Standard. |
| **7. Copayment for Primary Care Provider Visits** | • ***In-Network***: *$65 per visit.* When coinsurance is applied See Benefit Requirement #6<br>• ***Out-of-Network***: *Not specified* | **Recommendation:** Retain current Minimum Standard. |
| **8. Preventive and Wellness Services** | • ***In-Network:*** *Provided at no cost, per ACA rules.*<br>• ***Out-of-Network:*** *Subject to the plan's out-of-network fee requirements.*<br><br>*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.* | **Recommendation:** Retain current Minimum Standard. |
| **9. Pre/Post-Natal Care** | • ***In-Network:*** *Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules.*<br>• ***Out of Network:*** *Subject to the plan's out-of-network fee requirements.*<br><br>*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.* | **Recommendation:** Retain current Minimum Standard. |
| **10. Ambulatory Patient Services (Outpatient Care)** | *When coinsurance is applied See Benefit Requirement #6*<br><br>*When copayments are applied for these services:*<br><br>*Primary Care Provider: See Benefit Requirement #7*<br><br>*Specialty visits: Not specified* | **Recommendation:** Retain current Minimum Standard. |
| **11. Hospitalization** | • When coinsurance is applied See Benefit Requirement #6 | **Recommendation:** Retain current Minimum Standard. |

| Benefit Requirement | Current Minimum Standard (2025-26) | Recommended Revision (2027-28) |
|---|---|---|
| | • 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<br>• When copayments are applied for these services: Not specified | **Recommendation:** Retain current Minimum Standard. |
| **13. Rehabilitative & Habilitative Services** | • When coinsurance is applied See Benefit Requirement #6<br>• When copayments are applied for these services: Not specified | **Recommendation:** Retain current Minimum Standard. |
| **14. Laboratory Services** | • When coinsurance is applied See Benefit Requirement #6<br>• When copayments are applied for these services: Not specified | **Recommendation:** 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. | **Recommendation:** Retain current Minimum Standard. |
| **16. Other Services** | The full set of covered benefits is defined by the California EHB Benchmark plan. | **Recommendation:** Retain current Minimum Standard. |

# Health Care Accountability Workgroup 2026 Members

| Name | Organization |
|---|---|
| Beverly Popek | Office of Labor Standards and Enforcement (OLSE) |
| Giselle Olmedo | OLSE |
| Jane Bosio | Office and Professional Employees International Union (OPEIU) Local 29 |
| Evan Oravec | OPEIU 29 |
| Ketan Gima | Chinese Community Health Plan (CCHP) |
| Andrew Abou Jaoude | San Francisco International Airport (SFO) |
| Tiffany Yee | SFO |
| Rocio Molina | SF Human Services Network |
| Tina de Joya | Richmond Area Multi-Services (RAMS), Inc. |
| Kris Narahara | RAMS, Inc. |
| Chayla Gibson | Larkin Street Youth Services |
| Swati Kapadia | Progress Foundation |
| Christy Chess | Progress Foundation |
| Kim Tavaglione | SF Labor Council (SFLC) |
| Karl Kramer | SF Living Wage Coalition |
| Lynn Jones | EPIC |

**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, Thru April and May 2026, 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 two 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 fiscal climate; 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 June 15th, 2026 with an explanation of the process and description of the recommendations; and

WHEREAS, A review of the current Minimum Standards against 137 plans on the small business market in 2026 found that only 56 percent of silver plans are compliant; with the changes recommended here, this increases the share of compliant silver plans to 72 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 2027 and 2028:

| Benefit Requirement | New Minimum Standard |
| --- | --- |
| **Type of Plan** | Any type of plan that meets all the Minimum Standards as described below.<br><br>All gold- and platinum-level plans written in California are deemed compliant if:<br>• the employer covers 100 percent of both the plan premium and medical services deductible; and<br>• the plan covers all required covered services standards (5, 8-16)<br><br>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:<br>• 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.<br>• Employers may use any health savings or reimbursement product that supports compliance with this minimum standard.<br>• OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.).<br>• *The plan's out of pocket maximum cannot exceed the Federal out-of-pocket* limit for a self-only coverage plan during the plan's effective date. In 2027, the limit is $12,000<br><br>Out-of-Network: Not specified |
| **3. Medical Deductible** | • In-Network: $3,200 max<br>• Out-of-Network: Not specified |
| **4. Prescription Drug Deductible** | • In-Network: $500 max<br>• 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: 55 percent/45 percent<br>• Out-of-Network: 50 percent/50 percent |
| **7. Copayment for Primary Care Provider Visits** | • In-Network: $65 per visit. When coinsurance is applied See Benefit Requirement #6<br>• Out-of-Network: Not specified |
| **8. Preventive & Wellness Services** | • In-Network: Provided at no cost, per ACA rules.<br>• Out-of-Network: 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** | • In-Network: Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules.<br>• Out-of-Network: Subject to the plan's out-of-network fee requirements.<br><br>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<br>• When copayments are applied for these services:<br>• Primary Care Provider: See Benefit Requirement #7<br>• Specialty visits: Not specified |
| **11. Hospitalization** | • When coinsurance is applied See Benefit Requirement #6<br>• 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<br>• When copayments are applied for these services: Not specified |
| **13. Rehabilitative & Habilitative Services** | • When coinsurance is applied See Benefit Requirement #6<br>• When copayments are applied for these services: Not specified |
| **14. Laboratory Services** | • When coinsurance is applied See Benefit Requirement #6<br>• 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 June 15, 2026.________________

Mark Morewitz, MSW
Health Commission Executive Secretary