City and County of San Francisco
London N. Breed
Mayor

San Francisco Department of Public Health
Grant Colfax, MD
Director of Health

Office of Policy and Planning

MEMORANDUM

July 16, 2024

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

Through: Grant N. Colfax, MD, 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 2025 and 2026

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 July 16, 2024. We have also attached a draft resolution (Attachment D), for your consideration to ensure the Standards are updated in time 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 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. 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 FY24-25, the fee is $6.75 per hour worked per employee up to $270 per week for each employee.[1]

II: The HCAO Minimum Standards Review Process

The Health Commission has the sole authority to set the Minimum Standards. The last revision occurred in 2022 and went into effect on January 1, 2023. 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.

> "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 sought to develop recommendations to revise the Minimum Standards that would 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 employers have 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

[1] Office of Labor Standards & Enforcement (2024). Retrieved from https://www.sf.gov/information/health-care-accountability-ordinance

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 HCAO Workgroup

Starting on May 28, 2024, the workgroup met three times, with the last meeting on June 17, 2024. 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. Impact of Healthcare Costs on Health

Health care costs and medical debt are significant social determinants of health and are linked to adverse physical and mental health outcomes.[2] An estimated 23 million people (nearly 1 in 10 adults) owe significant medical debt,[3] a pressing issue even among people with insurance. Medical debt and high costs of healthcare can be financially damaging for those with or without insurance.[4] Many individuals avoid or delay medical care over concerns of high costs or medical debt. In the 2022 National Health Interview Survey (NHIS), more than 1 in 4 adults (28%) reported delaying or not getting healthcare due to cost, and Kaiser Family Foundation polling from March 2022 found that four in ten adults (43%) report that they or a family member in their household put off or postponed needed healthcare due to cost.[5] In California, more than one in three Californians (36%) report having some medical debt and more than half of Californians reported skipping or delaying at least one kind of health care due to cost in the past 12 months. Extensive research shows that delaying medical care can negatively affect health outcomes and as health conditions escalate, it can lead to extended hospital stays and more severe health outcomes.[6]

C. Health Care Trends

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

Health care expenditures continue to rise. According to the Center for Medicare and Medicaid Services (CMS), national healthcare expenditures grew 4.1% to $4.5 trillion in 2022, or $13,493 per person. CMS projects that over 2022-2031, average growth in national healthcare expenditures (5.4 percent) is projected to outpace that of average GDP growth (4.6 percent) resulting in an increase in the health spending share of GDP from 18.3 percent in 2021 to 19.6 percent in 2031.[7]. 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.[8]

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 7% over the last year.[9] Comparatively, there was an increase of 5.2% in workers' wages while inflation rose by 5.8%. Over the last five years, the average premium for family coverage has increased by 22% compared to an 27% increase in workers' wages and 21% inflation.[10] The average deductible amount in 2023 for workers with single coverage and a general annual deductible is $1,735. Among workers with single coverage and any deductible, the average deductible amount has increased 10% over the last five years and 53% over the last ten years.[11]

[2] Consumer Financial Protection Bureau (2022), Medical Debt Burden in the United States, Retrieved from https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf
[3] Rae, M. et al. (2022), The Burden of Medical Debt in the United States, https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states
[4] Commonwealth Fund (2023), Paying for It: How Healthcare Costs and Medical Debt are Making Americans Sicker and Poorer.www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey
[5] Rashit et al. (2024), How does cost affect access to healthcare? KFF, https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care
[6] Prentice, J. C., & Pizer, S. D. (2007). Delayed Access to Health Care and Mortality. Health Services Research, 42(2), 644–662.
[7] CMS, NHE Fact Sheet, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet; CMS (2023), National Health Expenditures: 2022 Highlights, https://www.cms.gov/newsroom/fact-sheets/national-health-expenditures-2022-highlights
[8] Wilson et al. (2023), 2023 Edition – California Health Care Spending, CHCF, https://www.chcf.org/publication/2023-edition-california-health-care-spending/#related-links-and-downloads
[9] KFF, 2023 Employer Health Benefits Survey, https://www.kff.org/report-section/ehbs-2023-summary-of-findings/
[10] KFF, 2023 Employer Health Benefits Survey, https://www.kff.org/report-section/ehbs-2023-summary-of-findings/
[11] KFF, 2023 Employer Health Benefits Survey, kff.org/report-section/ehbs-2023-summary-of-findings/

Despite overall expansions in health coverage, the observed rise in healthcare costs is contributing to serious 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 a 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.[12] Latino/x Californians are 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%).[13]

Health Care Coverage Improves in California. In recent years, California has made strong progress in ensuring health care coverage across the state. The share of uninsured Californians under age 65 reached a historic low in 2022 at 6.2%, compared to 7.4% in 2021.[14]

Covered California: Covered California saw a record number of Californians select plans for 2024. As of Jan. 31, there are 1,784,653 Californians who have chosen a health plan through Covered California for 2024, with 306,382 new enrollees and 1,478,271 renewing their coverage. The total surpasses the previous high set in 2022.[15] The record high Covered California enrollees is a result of both increased federal subsidies and a new cost-sharing program in California which reduce the cost of obtaining coverage.[16]

Medi-Cal Expansions: In the past few years, California has also expanded full-scope Medi-Cal to all adults, regardless of citizenship or immigration status. Effective January 1, 2024, California began providing full-scope Medi-Cal to individuals ages 26 to 49, regardless of citizenship or immigration status, who otherwise meet financial eligibility criteria for the program. This is estimated to impact 700,000 Californians.[17] The state previously expanded full-scope Medi-Cal for people ages 19 to 25 in 2020 and people 50 and older in 2022.[18] The expansion to adults 50 and older resulted in 286,000 undocumented older adult Californians receiving full-scope Medi-Cal.[19]

D. Post-COVID Impacts on health care trends.
Healthcare utilization significantly decreased after the onset of COVID-19 in 2020, and many outpatient visits and elective hospitalizations were delayed, avoided, or cancelled. Even in 2021, about one in five people ages 18 years and older (21%) reported delaying or foregoing medical care due to the pandemic. As of mid-to-late 2022, utilization of healthcare is generally rebounding, but remains below expectations based on pre-pandemic trends.[20]

E. Health Plan Review

The workgroup evaluated 178 small group health plans from Q2 2024 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 number of plan options available in the small business market.

[12] 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
[13] 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
[14] CFHF, California Achieves Lowest Uninsured Rate Ever, https://www.chcf.org/publication/california-achieves-lowest-uninsured-rate-ever-2022/
[15] Covered California, February 2024, https://www.coveredca.com/newsroom/news-releases/2024/02/08/february-8/#_ftn1
[16] Covered California, February 2024, https://www.coveredca.com/newsroom/news-releases/2024/02/08/february-8/#_ftn1
[17] CHCF, The Big Health Care Wins in California's State Budget, https://www.chcf.org/blog/big-health-care-wins-state-budget/
[18] DHS, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Adult-Expansion.aspx
[19] Office of Gavin Newsom (October 2022), Medi-Cal Expansion Provided 286,000 Undocumented Californians with Comprehensive Healthcare, https://www.gov.ca.gov/2022/10/19/medi-cal-expansion-provided-286000-undocumented-californians-withcomprehensive-health-care/
[20] KFF,healthsystemtracker.org/chart-collection/how-has-healthcare-utilization-changed-since-the-pandemic/

TABLE 1: Summary of Plans Analyzed by 2024 Workgroup

Carrier	Bronze	Silver	Gold	Platinum	Total
Aetna	7	6	10	3	26
Anthem Blue Cross	7	8	15	6	36
Blue Shield	9	7	9	7	32
Chinese Community Health Plan	2	2	2	4	10
Health Net	2	5	12	7	26
Kaiser	3	5	4	3	15
Sutter Health Plans	2	2	4	2	10
United Healthcare	3	4	8	8	23
Total	**35**	**39**	**64**	**40**	**178**

III: 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 a small number of silver-level plans on the marketplace are compliant with the current Minimum Standards. Based on the analysis of the 2024 small group health plans, only 33% of the 39 silver plans complied with the Minimum Standards. This was down from 70% in 2022 when the Standards were initially approved by the Health Commission.

With interest in ensuring a high number of silver plans employers could 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. Given this review and analysis, the following revisions are recommended to the current Minimum Standards:

- 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.
- Retain the framework that ensures a 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. copay, deductible, etc.) limits are adjusted to allow for a significant increase in silver plan availability.

Overall, workgroup members agreed on 15 of 16 Minimum Standards, with disagreements on *Minimum Standard 6: Coinsurance Percentages*. Attachment B provides a side-by-side comparison of the current Standards and recommendations. 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 2022, including the employer contribution, was $8,083 for single coverage and $22,818 for family coverage, approximately a 3% increase from the previous year.[21] Nationally, annual premiums for covered workers have increased 20% over the past five years, and 43% over the last ten years.[22] 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.

[23] California Health Care Foundation, California Employer Health Benefits Survey, 2022, https://www.chcf.org/wp-content/uploads/2023/04/CAEmployerHealthBenefitsAlmanac2023.pdf

[22] Kaiser Family Foundation, 2022 Employer Health Benefits Survey. https://www.kff.org/report-section/ehbs-2022-summary-of-findings/#:~:text=In%202022%2C%20the%20average%20annual,%25%20and%20inflation%20increased%208%25.

Minimum Standard 2: Annual Out-of-Pocket Maximum

- ***In-Network:*** Employers must the cover out-of-pocket 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 (out-of-pocket) Maximum is synced to the California Patient-Centered Benefit Design (PCBD) OOP limit for silver coinsurance or copay plans.
- ***Out-of-Network:*** *Not specified.*

Nearly all health insurance plans set a specific 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 workgroup 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., copays, out-of-pocket maximum) 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.

Beginning in 2019, the workgroup agreed to tie the OOP maximum to the amount set by the California Patient-Centered Benefit Design (PCBD) OOP benchmark for a silver coinsurance or copay plan. This decision to sync the Minimum Standard to a benchmark provided greater predictability for employers to anticipate and prepare for subsequent plan years while allowing them to access a larger number of plans. In the analysis of Q2 2024 health plans, the OOP max benchmark limit was identified as the most significant factor that reduced the availability of silver plans. To increase plan availability, the workgroup agreed that the OOP maximum should be synced to the Federal out-of-pocket limit for a self-only coverage plan. In 2025, the limit will set to $9,200. Under this recommended standard, employers will be responsible for up to $4,600 of employee OOP expenses if they choose a silver plan for their employees, up from $4,375, or an additional $225 from the current limit.

With this increase in cost responsibility for employers, the group recommended adjusting the copay to $65 per visit and the prescription drug deductible to $400 max, but were split on changing the coinsurance rates to 55%/45%. The rationales for these recommendations are discussed in greater detail in their respective Minimum Standard sections. Adjusting the standards to these levels would increase to percentage of compliant silver plans from 33% to 77% based on the available Q2 2024 small group plans. This compliance rate is comparable to when the standards were previously revised in 2022.

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.

Lastly, members specified that there should be increased 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. DPH will work with OLSE to explore additional ways employers/employees can be messaged about the standards and options for compliance.

Recommendation:

- Retain Minimum Standard to require employer cover out-of-pocket 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 will be synced to the Federal out-of-pocket limit for a self-only coverage plan.

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 increasing the medical deductible does not impact availability of silver

plans. Of plans analyzed, 79% of plans had a medical deductible of $3,000 or less, with the breakdown of 0 Bronze plans, 38 Silver plans, 63 Gold plans, 40 Platinum plans.

Recommendation: Retain current Minimum Standard.

Minimum Standard 6: Coinsurance Percentages

- ***In-Network:*** *40% / 60%*
- ***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. The workgroup evaluated maintaining the standard at 60%/40%, which would lessen the financial burden on employees, yet reduce the availability of compliant silver plans. This would be an issue for smaller non-profit organizations already struggling with sustainability issues. Silver plans increasingly are adopting higher coinsurance levels that make maintaining the current standard untenable for maximizing availability of compliant silver plans.

The workgroup was split on whether to increase the coinsurance rate. Some members recommended increasing the coinsurance only if the employers were required to cover a greater percentage of the employee out-of-pocket expenses. This proposal raised concern among employers, as they highlighted that they are already covering a significant portion of OOP expenses along with the entire plan premium. Further, by syncing the OOP maximum to the Federal out-of-pocket limit, employers noted that they will be responsible for even more employee health expenses compared to the current standard. Lastly, increasing the percentage responsibility would upend the framework members had agreed to at the outset of the workgroup where employers cover 50% of OOP expenses in exchange for adjusting the cost-sharing standards to ensure silver plan availability.

Adjusting the coinsurance rate from 60%/40% to 55%/45% for in-network services would, in tandem with the increases to the copay and prescription drug deductible maximum, increase the availability of silver plans to 77%. 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. Concerningly, when plan data was analyzed a year after the current 2023-24 Standards went into effect, the percentage of compliant silver plans dropped by 56%. Setting the coinsurance rate to 55%/45% will better ensure the Standard's durability for the two-year life cycle. While concerns were raised about employees experiencing greater cost sharing expenses under the proposed coinsurance rate, the increases in the OOP limit will require the employers to cover an additional up to $225 in health expenses, which would help to defray the proposed adjustment.

Recommendation: Revise Minimum Standard to set Coinsurance at 55%/45% for in-network services.

Minimum Standard 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*

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, the copay limit was identified as a top limiting factor in the availability of silver plans. The workgroup determined that given the decision to retain the requirement that the employers cover a percentage of the OOP Maximum, copayments should be increased to $65 per visit in order to increase the availability of silver plans.

Recommendation: Revise Minimum Standard to set copayment for in-network at $65 per visit. When coinsurance is applied See Benefit Requirement #6

Minimum Standard 4: Prescription Drug Deductible

- ***In-Network:*** *No higher than a $300 deductible.*
- ***Out-of-Network:*** *Not specified.*

Prescription drug spending increased 8.4% to $405.9 billion in 2022, faster than the 6.8% growth in 2021.[23] Looking forward, retail prescription drug spending is projected to increase at an average rate of about 5.2% from 2025-2030.[24] Similar to a deductible for medical services, some plans include

[23] 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

[24]Center for Medicare and Medicaid Services (2022), National Health Expenditure Projections 2023-2032 Forecast Summary. Retrieved from https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf

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 $300 maximum limits the availability of silver plans, and reached consensus to change the standard and increase the maximum to $400. 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 $400 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 2022, 71% of California workers with coverage had a three- or four-tier cost-sharing formula for prescription drugs, compared to about 78% nationally. The share of California workers with four tiers has increased substantially over time, from 4% in 2012 to 22% in 2022.[25] 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 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 an untenable 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 with the City entering a sustained period of budget deficits, nonprofits will face significant budget cuts. These cuts, on top of rising costs of doing business, healthcare costs, and costs of living will collectively contribute to profound pressures to the city's non-profit sector. Members expressed that this dynamic creates significant challenges to these organizations to provide affordable and comprehensive health coverage to their employees while ensuring employees receive livable wages.

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 considered numerous options and came to consensus on 15 of 16 the 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;

[25] California Healthcare Foundation, 2023 CA Employer Health Benefits, Retrieved from https://www.chcf.org/wp-content/uploads/2023/04/CAEmployerHealthBenefitsAlmanac2023.pdf

- 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;
    - Co-Insurance in-network rate revised to 55%/45%
    - Copayment for PCP visits revised to $65.
    - Prescription Drug Deductible revised to $400 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, 2025.

Recommendations for New Minimum Standards, 2025-2026

The following summarizes the workgroup's review and recommendations for the Minimum Standards effective January 1, 2025 through December 31, 2026. A health plan must meet all 16 minimum standards to be deemed compliant.

Benefit Requirement	Current Minimum Standard (2023-24)	Recommended Revision (2025-26)
Type of Plan	Any type of plan that meets the Minimum Standards as described below. 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:***
	  ○ 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* to the California Patient-centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan.
	
	• ***Out-of-Network****: Not specified*
		Recommendation:
		• Revise Minimum Standard to require the plan's out of pocket maximum not exceed the Federal out-of-pocket limit for a self-only coverage plan during the plan's effective date.
		• Retain Standard's other provisions as is.

3. Regular (Medical Services) Deductible	• ***In-Network****: $3,000 max.* • ***Out-of-Network****: Not specified*	**Recommendation**: Retain current Minimum Standard.
4. Prescription Drug Deductible	• ***In-Network****: $300 max.* • ***Out-of-Network****: Not specified*	**Recommendation:** • Revise Minimum Standard to set Prescription Drug Deductible for in-network at $400 max.

Benefit Requirement	Current Minimum Standard (2023-24)	Recommended Revision (2025-26)
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****: 60%/40%* • ***Out-of-Network****: 50%/50%*	**Recommendation:** • Revise Minimum Standard to set Coinsurance for in-network to 55%/45%.
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*	**Recommendation:** • Revise Minimum Standard to set copayment for in-network at $65 per visit. When coinsurance is applied See Benefit Requirement #6
8. Preventive and 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.*	**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.* • ***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.*	**Recommendation:** Retain current Minimum Standard.
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*	**Recommendation:** Retain current Minimum Standard.

Benefit Requirement	Current Minimum Standard (2023-24)	Recommended Revision (2025-26)
	Specialty visits: Not specified	
11. Hospitalization	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified	**Recommendation:** Retain current Minimum Standard.
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	**Recommendation:** Retain current Minimum Standard.
13. Rehabilitative & Habilitative Services	• When coinsurance is applied See Benefit Requirement #6 • 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 • 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 2024 Members

Name	Organization
Beverly Popek	Office of Labor Standards and Enforcement
Jade San Diego	Office of Labor Standards and Enforcement
Jane Bosio	OPEIU 29
Stephanie Passino	Chinese Community Health Plan (CCHP)
Toni Bonde	CCHP
Tiffany Yee	SFO
Debbi Lerman	SF Human Services Network
Tina de Joya	RAMS, Inc.
Kris Narahara	RAMS, Inc.
Chayla Gibson	Larkin Street Youth Services
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. 24-11

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 2024, 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 three 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 post-pandemic environment; 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 16th, 2024 with an explanation of the process and description of the recommendations; and

WHEREAS, A review of the current Minimum Standards against 178 plans on the small business market in 2024 found that only 33 percent of silver plans are compliant; with the changes recommended here, this increases the share of compliant silver plans to 77 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 2025 and 2026:

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 Federal out-of-pocket* limit for a self-only coverage plan during the plan's effective date. In 2025, the limit is $9,200 Out-of-Network: Not specified
3. Medical Deductible	• In-Network: $3,000 • Out-of-Network: Not specified
4. Prescription Drug Deductible	• In-Network: $400 • 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 • 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 • Out-of-Network: Not specified

Benefit Requirement	New Minimum Standard
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 16, 2024._____

Mark Morewitz, MSW
Health Commission Executive Secretary