City and County of San Francisco **Department of Public Health**

Gavin Newsom
Mayor

Mitchell H. Katz, MD
Director of Health

M E M O R A N D U M

December 7, 2010

To: James Illig, President and Members of the Health Commission

Through: Anne Kronenberg, Deputy Director of Health, Director of Planning and Administration

From: Frances Culp, Senior Health Program Planner

Re: Health Care Accountability Ordinance – Suggested Revisions to the Minimum Standards for 2010

As required by the San Francisco Health Care Accountability Ordinance (HCAO), the Department of Public Health has recently undertaken a thorough review of the current HCAO Minimum Standards in relation to the current health care insurance market in California. These Standards set the structure for a compliant health plan that employers subject to the HCAO must follow when making arrangements for their employees' health plan. The attached report describes the findings and recommendations made by the HCAO Minimum Standards Work-Group convened by DPH. I respectfully request that you consider the Work-Group's recommendations, summarized in Attachment A to this report, and look forward to discussing the findings with the members of the Health Commission on December 7, at the Finance & Planning Committee, and later at the full Health Commission meeting. We have also attached a draft resolution, for your consideration to ensure that the Standards are updated in time for the first of the New Year.

Section A: The Health Care Accountability Ordinance & the Minimum Standards

The Health Care Accountability Ordinance (HCAO) represents one of San Francisco's early pioneering efforts to reduce the number of uninsured in San Francisco. HCAO went into effect on July 1, 2001. It requires that employers doing business (through contract or lease) with the City offer health insurance coverage to their employees who are working on the City contract or the property in question that meets a set of Minimum Standards or pay a fee to the Department of Public Health (DPH) to offset costs of health care provided to the uninsured.

The Health Commission has the sole authority to set these Minimum Standards. The HCAO notes in Section 12Q.3.(a)(1): "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." Some businesses are exempt from HCAO, including small businesses (non-profit small businesses are defined as 50 or fewer employees and for-profit small businesses as 20 or fewer employees), public entities (e.g., UCSF), and others. The Office of Labor Standards and Enforcement (OLSE) is the primary enforcement body for HCAO, and works closely with DPH to ensure proper compliance among contractors and lessees.

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. This fee is set through an automated process using certain metrics set in the Ordinance. In FY 2009-10, there were 32 businesses that paid the fee to DPH, for a total of $801,205. The yearly amounts varied from less than $2,000 to a maximum of $254,000. The reasons for paying these fees vary widely; in some cases it is because the company's policy of the health insurance start date is not in keeping with what is required in the HCAO: no later than the first of the month that begins after 30 days from the start of employment. In other cases, employers are paying for seasonal workers that are not insured or large payments as restitution required after an OLSE audit.

Section B: HCAO Minimum Standards Review Process

The Health Commission last acted to revise the standards in 2008, making them effective on November 1, 2008. As has been DPH's practice since 2004, DPH convened a group of stakeholders, including non-profit and for-profit employers, labor representatives, airport administrators and businesses, health insurance brokers, City Departments, and advocates to bring their expertise and experiences to this process. The HCAO Minimum Standards Work-Group (Work-Group) agreed at the first meeting to review the current HCAO Minimum Standards and suggest possible revisions.

With this directive in mind, the Work-Group's members consented to a goal to create a revised set of Minimum Standards that would increase health insurance options for employers, retain the comprehensive benefit package for employees, and consider affordability for both.

It is understood by even the most casual observer of the health insurance market that costs are raising exponentially for all participants in the health care system. Consider the following findings from 2009 regarding premium cost increases from the California Health Care Foundation (CHCF):

- Health insurance premiums increased an average of 7.5 percent in California in 2009, compared to a .6 percent decrease in overall consumer prices.

- Since 2002, premiums have increased by 117.5 percent, more than four times the 23.1 percent increase in the state's overall inflation rate.

At the same time, employees are being asked to pay more for their coverage in all forms of cost sharing, including deductibles (an amount that must be paid by the enrollee before all or most services are covered by the health plan), coinsurance (a percentage of the overall charge paid by the enrollee), and higher copayments (a fixed dollar amount paid by the enrollee to access a service). High deductible health plans (HDHP), often combined with a savings option, are being offered with greater frequency. Findings show increasingly that these plans have mixed results and there are concerns about lack of affordability impacting access. Most recently, the Archives of Internal Medicine published on November 23, 2010 the findings of a study that found that 57 percent of low-income families delayed or avoided care because of cost, while 42 percent of higher-income families did the same. (HDHPs are generally defined as having a deductible over $1,000 for individuals.) Given the many variables and concerns about affordability, it is more important than ever to ensure that the HCAO Minimum Standards are flexible enough to withstand the rapid changes in the health insurance market, while protecting employees and allowing reasonable options for employers (lest they drop coverage altogether).

Starting on September 22, the Work-Group met four times, with the last meeting on November 11. Anne Kronenberg, DPH's Deputy Director of Health, Director of Planning and Administration, chaired the Work-Group and Frances Culp, DPH's Office of Policy & Planning, provided staff support. Many of the Work-Group's members had participated in this process in previous years, with some going back as far as the drafting of the original Ordinance. Others were new to the process, including representatives from for-profit businesses as recommended by the Health Commission in 2008. A list of the Work-Group's membership (including those who were invited, but could not commit to the process) can be found in Attachment B. All members of the Work-Group but one approved the recommendations in this report. The Living Wage Coalition expressed opposition to changes that would allow employers to raise the cost-sharing amount for employees from what they are currently.

Of great assistance to the group for information and analysis about the health insurance market were brokers from three different firms. These brokers provided information crucial to the process, answered the group's questions, and prognosticated about the many changes coming to the health insurance market. In light of health reform, this was especially useful to the Work-Group. The brokers provided a broad base of knowledge, but were also specialists in the small business health insurance market.

As in the past, the concrete health insurance plan information that the Work-Group used to base decisions on comes from the small business market. The State defines a small business as having 2 to 50 employees for the purposes of health insurance. DPH used this part of the health insurance market because while many of these businesses are exempt from the HCAO, small businesses must buy "off-the-shelf" insurance products, while larger businesses may create their own. Therefore, it is crucial that the HCAO Minimum Standards are set so that there are a good number of plan options available in the small business market for the for-profit businesses between 20-50 employees. In addition, the Work-Group used "off-the-shelf" plans as a proxy to extrapolate what is normal in the overall health insurance market. The group reviewed in detail health insurance plans offered to small businesses by Anthem Blue Cross, Blue Shield, Health Net, and Kaiser Foundation Health Plan.

Section C: Minimum Standards – Revisions

In order to be compliant with HCAO, the employer must offer the employee a plan that meets or exceeds the Minimum Standards. The Work-Group reviewed 26 Health Maintenance Organization (HMO) plans and 16 Preferred Provider Organization (PPO) plans, for a total of 39 plans. In 2008, the Work-Group reviewed a similar number of plans, but focused only on HMOs because these were the only types of plans allowed under the Standards at this time.

Given our review and analysis, there are several recommendations for change, ensuring that the Minimum Standards are appropriate now and for another two years. The following points describe the current Minimum Standards and the recommendations for change:

1. **Current *(2008)* Benefit Requirement - Type of Plan Required: The plan that meets the Minimum Standards must be an HMO.** The requirement that the compliant plan be an HMO has been part of the Minimum Standards since the HCAO was first made effective in 2001. At this time, HMOs were more affordable for employers and employees alike, and on average HMOs offered protection from much of the expensive cost-sharing found in other plans. HMOs traditionally required copayments that varied based on type of service, while PPOs required some mix of deductibles and coinsurance.

   In recent years, the lines began to blur between types of plans. In 2009, in the United States, 16 percent of HMO enrollees were required to pay an annual deductible. Just one year later, this increased to 28 percent of HMO enrollees. This compares to 77 percent of PPO enrollees in 2010 (up from 74 percent in 2009).[1] In addition to PPOs, employers are choosing more HDHPs, Exclusive Provider Organizations (EPOs), and other models. EPOs can be considered a hybrid HMO/PPO, or an extreme version of a PPO, because they use deductibles and coinsurance, but do not reimburse for out-of-network care. As the types of plans became less distinguishable by type, the only reason that some plans did not meet the HCAO Minimum Standards was that it was considered a PPO or EPO. This, by far, was DPH's most commonly heard complaint from employers regarding the HCAO Minimum Standards.

   For all these reasons, it is recommended that we allow any type of plan, as long as it adheres to the Minimum Standards in their entirety. This change will allow more options for employers. The concerns about the impact of employees using other types of plans are addressed in the other requirements, supporting the integrity of the plan that is offered to employees.

   - **RECOMMENDATION: Any type of plan that meets the Minimum Standards should be allowed.**

2. **Current *(2008)* Benefit Requirement – Employee Premium Contribution: The employer must pay 100% of the employee's health coverage premium.** The current Minimum Standards require employers to pay the full premium, not allowing any portion of the cost to be passed on to the employee. Premiums reflect the amount that it costs to provide health coverage to an employee. Premium costs are usually shared

[1]The Kaiser Family Foundation & Health Research & Educational Trust; *Employer Health Benefits, 2010 Summary of Findings*; Sept. 2010.

between the employer and the employee. In fact, in 2009, 70 percent of all California businesses required that employees pay some portion of the premium.[2]

It was agreed by all that this important protection for workers that should be retained in the Standards. Many of the employees subject to HCAO are low-wage workers; a requirement that employees pay a portion of the premium may cause some employees to decline the coverage. (HCAO requires employers to offer adequate coverage, but employees are not required to accept.) In California, the average monthly premium for single coverage was $428 per month in 2009, and the average worker paid $564 annually for their share of the premium.[3]

On the other hand, there was a concern expressed that high premium costs have caused many employers, especially non-profits, to increase cost-sharing and/or discontinue family coverage for workers. Collecting some portion of the premium cost from the employees for individual coverage would help some employers to subsidize family coverage. Ultimately, the group decided that while increasing family coverage is a laudable goal, the priority of the HCAO has always been to cover individual workers. There was also concern about enforcement of such a rule, and the fairness to those workers without dependents.

- **RECOMMENDATION: No change**

3. **Current *(2008)* Benefit Requirement – Annual Out-of-Pocket Maximum: No higher than a $3,500 maximum, which may include a prescription drug deductible:** Nearly all health insurance plans set a specific Out-of-Pocket (OOP) maximum, which limits the insured's financial liability for the year. The amount a subscriber pays during the year in copayments and some other cost-sharing amounts cannot exceed the OOP maximum. The current annual OOP maximum in HCAO's Minimum Standards is set at $3,500 and may be combined with a prescription drug deductible.

   The recommendation is to raise the maximum amount by $500, but to also capture more possible cost-sharing than the 2008 arrangement. Carriers set up their plans differently, with some OOP maximums including all copayments, others excluding them. These details can be confusing to the enrollee. This change simplifies and clarifies the requirements around the employee's cost sharing and ensures a hard and fast amount over which no employee's health costs can go for the year.

   - **RECOMMENDATION: Increase Annual Out-of-Pocket (OOP) Maximum to $4,000, including all subscriber cost-sharing in the plan, which includes deductibles of any kind, copayments, and coinsurance for in-network services.**

4. **Current *(2008)* Benefit Requirement – Prescription Drug Deductible: Allowed, but may not exceed $3,500 when added to the plan's OOP maximum.** Prescription drug deductibles were becoming common enough two years ago to influence the Work-

[2] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2009.
[3] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2009.

Group to add the option to the Minimum Standards for the first time. As noted above, the amount was flexible, but when combined with the OOP maximum could not exceed $3,500. For example, if the plan's OOP maximum was $3,000 and the prescription drug deductible was $500, that plan would be compliant. The drug deductibles are most commonly associated with only brand-name and non-formulary drugs, while generic drugs are either usually free or occasionally have a low copayment. Of the plans reviewed by the Work-Group this year (HMO and PPOs), half had a drug deductible of either $150 or $250 for brand and non-formulary drugs, while the remaining 50 percent had no drug deductible.

The increased maximum out-of-pocket maximum of $4,000 contained in Recommendation 3 above includes all deductibles. Thus, there is no longer a need for a separate provision for prescription drug deductibles.

- **RECOMMENDATION: Eliminate the separate prescription drug deductible provision as all deductibles are included in the $4,000 Out-of-Pocket Maximum recommended above**

5. **Current *(2008)* Benefit Requirement – Regular (Medical Services) Deductible*: Not allowed.*** A deductible is the set amount an insured individual is required to pay for health care services before complete insurance coverage starts. After the full amount of the deductible has been paid, the subscriber is required to pay only the cost of the copayment for the remainder of the year. The Minimum Standards were first set at a time that deductibles were highly unusual among HMOs. On the national level, among workers with an HMO plan, nine percent of workers had a deductible in 2004 (the first year this measure was tracked) rising to 28 percent in 2010.

   In 2009, deductibles were required for 77 percent of those with PPOs, and 7 percent of those with HMO plans.[4] Of the 2010 plans the Work-Group reviewed, 56 percent of the plans did not require a deductible and the remaining 45 percent required an annual deductible ranging from $250 to $2,000. It would be a significant challenge to retain the requirement disallowing deductibles based on these changes in the market.

   The increased maximum out-of-pocket maximum of $4,000 contained in Recommendation 3 above includes all deductibles. Thus, there is no longer a need for a separate provision for regular deductibles.

   - **RECOMMENDATION: Eliminate the separate regular deductible provision as all deductibles are included in the $4,000 Out-of-Pocket Maximum recommended above.**

6. **Current *(2008)* Benefit Requirement – Prescription Drug Copayments*: Not Specified.*** Most health insurance plans have moved to a two or three-level tiered copayment system for prescription drugs, with a low/no copayment for generic drugs, a higher for brand-name drugs and the highest for non-formulary drugs. In California, the most recent data shows that only 9 percent of covered workers pay only one copayment

[4] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2009.

amount for drugs, less than half of what it was in 2003 (20%). The remaining majority of insured employees are paying a variety of amounts, with the most common 3-tiers.

Because of the variation in plan design, the recommendation is to retain the current requirement and avoid setting a specific dollar amount for prescription drugs. The plans reviewed by the Work-Group showed twelve different arrangements, implying that this volatile part of the insurance market is sure to be changing significantly from year to year. Additionally, the increased maximum out-of-pocket maximum of $4,000 contained in Recommendation 3 above includes all copayments. Thus, there is no need to specify a limit on prescription drug copayments.

- RECOMMENDATION: **No change.**

7. **Current *(2008)* Benefit Requirement – Coinsurance amounts: Not specified.** Much like deductibles, coinsurance was traditionally associated with PPOs, but is starting to also appear as a component of HMOs. All PPOs and other similar plans with an in-network and out-of-network component employ coinsurance as a percentage that is significantly lower for an in-network provider. Among the plans the Work-Group reviewed, the majority of HMOs (80%) did not require coinsurance, but instead depended on copayments as the only cost-sharing mechanism. All PPOs required coinsurance, ranging from an employee responsibility of 10 percent in-network/30 percent out-of-network to a high of 45 percent in-network/50 percent out-of-network.

   This recommendation would cap the coinsurance amount an employee can be asked to pay for services at 20 percent for in-network services and 50 percent for out-of network services, to avoid plans that require a significant financial burden. Given the recommendation that various types of plans be allowable under the new Minimum Standards, it is important to specify the coinsurance amount. The advice given by the brokers advising the Work-Group indicates that a 20/50 coinsurance will be adequate for employers' choice now and in the future. The Work-Group would also like the Minimum Standards to specify that all coinsurance amounts paid by the subscriber for in-network services are included in the OOP maximum. This will protect the worker from plans that exclude these payments from OOP maximums, meaning that there is no point at which the worker is fully covered for necessary medical services.

   - RECOMMENDATION: **Establish a maximum of 20% coinsurance for in-network services and 50% coinsurance for out-of-network services with in-network coinsurance included in the $4,000 Out-of-Pocket maximum recommended above.**

8. **Current *(2008)* Benefit Requirement – Copayment for Preventive Care Visits and Services: $30 maximum.** In 2008, the Minimum Standards specified that copayments for all primary care office visits must not exceed $30. Recent health reform changes require that preventive care visits and certain services be provided free of charge to the subscriber. This encourages individuals to take advantage of the preventive care visits and screenings, without any cost concerns. This recommendation simply keeps the HCAO Minimum Standards in line with changes due to health reform.

- **RECOMMENDATION: In-network preventive care services are not subject to a deductible, copayment, or coinsurance, per health reform rules effective 9/23/10.**

9. **Current *(2008)* Benefit Requirement – Copayment for Physician Office Visits (primary and prenatal/maternity): $30 maximum.** The vast majority of health plans, regardless of type, require that an office visit copayment be $30 or under. This was true two years ago, and remains true today. Of the plans reviewed by the Work-Group, only 16 percent had copayments over $30 per visit, ranging between $35 and $45. There has been little change in this area over the past two years.

    - **RECOMMENDATION: No change.**

10. **Current *(2008)* Benefit Requirement – Services: The noted following services must be covered, but associated copayments amounts are not specified.**
    - Hospital inpatient, physician and hospital services
    - Rehabilitative therapies, outpatient and inpatient
    - Outpatient services and procedures
    - Surgery and anesthesia
    - Outpatient diagnostic services (x-ray, labs, etc.)
    - Prenatal and maternity care, including delivery services & postpartum care
    - Physical, occupational and speech therapy
    - Skilled nursing services
    - Home health services
    - Durable Medical equipment
    - Organ transplants
    - Cancer clinical trials
    - Hospice care
    - Mental Health Services – Inpatient & Outpatient
    - Alcohol and Substance Abuse Services – Inpatient & Outpatient

    It is a priority to DPH to ensure that the health benefit coverage offered to employees subject to HCAO is not limited to catastrophic care and that these employees are not among the chronically under-insured. The list of services has not changed since the Minimum Standards were first created, though up until 2004, each of the services had a copayment maximum associated with it. This approach became onerous for the employers, as the changes in the health insurance market were too frequent. Employers complained that because the Minimum Standards are all or nothing, plans easily fell out of compliance at renewal time. In the end, it is the OOP Maximum that that makes the most difference to the employee, protecting him/her from paying too much in case of major health event, or an expensive chronic condition.

    - **RECOMMENDATION: No change, but a clarification that when coinsurance is applied to the services, it may not ask the subscriber to pay more than 20 percent in-network and 50 percent out-of-network (see #7 above), and if copayments are required the maximum amount is not specified.**

11. **Current Benefit Requirement – Emergency Room Services & Ambulance: These services must be covered, but a copayment amount is not specified.** Due to changes

made effective through health reform, emergency medical services now have special coverage regulations. As of September 23, 2010, fully-insured and self-insured plans (other than grandfathered plans) must cover emergency services at in-network rates regardless of the provider and without prior authorization. The Minimum Standards should go one step further and not allow the exception for grandfathered plans. The issue of emergency coverage became a concern to the Work-Group due to the emergence of plans, like some EPOs, that do not approve of any services provided at out-of-network facilities, potentially including medical emergencies.

- **RECOMMENDATION: Emergency services must be covered and the in-network cost-sharing amount must also apply to emergency services received from an out-of-network provider.**

It was the Work-Group's aim to ensure that at least half of the small business HMO plans available in the insurance market meet the revised Minimum Standards. With the changes suggested above, 26 of the 39 plans (66%) reviewed by the Work-Group would meet the Minimum Standards. Similar to this finding, in 2008, 62 percent of the reviewed plans were compliant with the recommended new Standards.

Section F: Conclusion

In conclusion, DPH fully supports the HCAO and has a strong interest in seeing the Ordinance meet its objective of reducing the numbers of uninsured and thereby enhancing the quality, stability and productivity of the workforce on the City's contracts and leases. While health reform is bringing about many changes in the health insurance market, many of the changes at this point are protections for the insured. Where appropriate, these recommendations integrate the appropriate health reforms into the HCAO Minimum Standards. While changes are on the horizon to expand access to health coverage for individuals, we will not see those for several years. Even with these changes, the importance of employer-based health insurance will not be lost, nor will the place of HCAO in San Francisco's multi-pronged effort to increase the number of insured residents.

The attached draft resolution (Attachment C) requests approval to revise the Minimum Standards effective January 1, 2011. These new Standards meet the goals set for the HCAO Minimum Standards Work-Group. They protect employees from inordinate cost increases by keeping the copayment maximum at the same amount, retaining the comprehensive benefits list, capping the coinsurance at an amount that is at the average for small business plans, and by combining the cost-sharing amounts into one overall maximum for the year. In addition, the flexibility is increased for employers which in turn allows them to choose an affordable compliant plan. This is done by removing the HMO requirement and allowing other types of plans, allowing medical deductibles for the first time, and retaining flexibility in copayment amounts for most services/visits.

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Health Care Accountability Ordinance:
Recommendations for New Minimum Standards

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

#	Benefit Requirements	Current Min. Standards ('08)	Recommendations (2010)
6	Prescription Drug Copayments	Not specified.	Not specified. Coverage of non-formulary drugs not required.
7	Coinsurance Percentages	Not specified.	20% in-network 50% out-of-network
8	Copay for Preventive Care Visits & Services[5]	$30 maximum.	In-Network services are not subject to a deductible, copay, or coinsurance (per health reform rules). Preventive care services from an out-of-network provider are subject to the plans out-of-network requirements.
9	Copayments for Physician Office Visits for Primary Care, Perinatal/Maternity	$30 maximum.	$30 maximum. Out-of-Network: Not specified.
10	Services: • Hospital inpatient, physician & hospital service • Rehabilitative therapies, outpatient and inpatient • Outpatient services and procedures • Surgery & anesthesia • Organ transplants • Cancer clinical trials • Outpatient diagnostic services (x-ray, labs, etc.) • Perinatal and maternity care, including delivery services and	These services must be covered, but a copayment amount is not specified.	These services must be covered. When coinsurance is applied to services: 20% in-network 50% out-of-network When copayments are applied for these services: Not specified.

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

#	Benefit Requirements	Current Min. Standards ('08)	Recommendations (2010)
	postpartum care • Physical, Occupational, and Speech Therapy • Skilled nursing services • Home health services • Durable medical equipment • Hospice care		
11	Mental Health Services ♦ Inpatient & Outpatient Alcohol & Substance Abuse Services ♦ Inpatient & Outpatient	These services must be covered, but a copayment amount is not specified.	These services must be covered. When coinsurance is applied to services: 20% in-network 50% out-of-network When copayments are applied for these services: Not specified
13	Emergency Room Services & Ambulance[6]	These services must be covered, but a copayment amount is not specified.	Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.

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

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HEALTH CARE ACCOUNTABILITY WORK-GROUP
LIST OF INVITEES

Organization	Name	Attended Meeting(s)
Chapman Insurance	Valli Bowman	Yes
Conard House	Carol Kossler Roger Mendoza	Yes
Department of Public Health	Anne Kronenberg Colleen Chawla Frances Culp	Yes
Emporio Rulli	Debbie	No
Enterprise Rent-A-Car	Kendall Stulce	Yes
Episcopal Community Services	David Medina	No
Huckleberry Youth Programs	Frank Landin	Yes
Human Services Network	Debbi Lerman	Yes
IHSS Consortium	Daniel Crain	Yes
Larkin Street Youth Services	Sharla Walker	Yes
Levinson Benefits Group	Lynn Jones	Yes
Office of Labor Standards and Enforcement	Richard Waller	Yes
OPEIU Local #3	Connie Ford	No
Primeflight Aviation	Ray Klinke	No
Richmond Area Multi Services Center (RAMS)	Trina DeJoya	Yes
San Mateo Labor Council	Julie Lind	Yes
San Francisco Airport	Bill Wong	Yes
SF Living Wage Coalition	Karl Kramer Alice Rogoff	Yes
Shargel & Associates	Cecilia Paul	Yes
Virgin America	Kevin Ng	Yes

AMENDING THE HEALTHCARE ACCOUNTABILITY ORDINANCE MINIMUM STANDARDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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