City and County of San Francisco
Edwin M. Lee
Mayor

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

Office of Policy and Planning

M E M O R A N D U M

October 31, 2012

To: Sonia Melara, President, and Members of the Health Commission

Through: Barbara A. Garcia, MPA, Director of Health

Through: Colleen Chawla, Deputy Director of Health, Director of Policy and Planning

From: Jim Soos, Assistant Director of Policy and Planning
Patrick Chang, Public Service Trainee

Re: Health Care Accountability Ordinance – Suggested Revisions to the Minimum Standards for 2013

As required by the San Francisco Health Care Accountability Ordinance (HCAO), the Department of Public Health has recently undertaken a thorough biannual review of the current the HCAO Minimum Standards in relation to the current health care insurance market in California. These Standards set the minimum requirements for a compliant health plan that employers subject to the HCAO must meet when providing their employees with a health plan. The attached report describes the findings and recommendations made by the HCAO Minimum Standards Work Group convened by DPH. We 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 November 6, 2012. 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. The 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 that meets a set of Minimum Standards to their employees who are working on a City contract or on property leased from the City, 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 the HCAO, such as small businesses (non-profit small businesses are defined as 50 or fewer employees and for-profit small businesses with 20 or fewer employees) and public entities (e.g., UCSF). The Office of Labor Standards and Enforcement (OLSE) is the primary enforcement body for the 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 automatic process using certain metrics set in the Ordinance. In FY 2011-2012, there were 56 businesses that paid the fee to DPH, for a total of $1,502,904.48. The yearly amounts varied for individual businesses from less than $500 to a maximum of $280,680. 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 who are not insured or large payments as restitution required after an OLSE audit.

Section B: The HCAO Minimum Standards Review Process

The Health Commission last acted to revise the standards in 2010, making them effective on January 1, 2011. As has been DPH's practice since 2004, DPH convened a Work 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 agreed at the first meeting to review the current HCAO Minimum Standards and to recommend 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 provide an array of health insurance options for employers, retain the comprehensive benefit package for employees, and consider affordability for employers and employees.

The costs of health insurance are rising rapidly for all participants in the health care system. Consider the following findings from 2011 regarding premium cost increases from the California Health Care Foundation (CHCF):

- Health insurance premiums increased an average of 8.1 percent in California in 2011, compared to 3.1 percent increase in overall inflation.
- Since 2002, premiums have increased by 153.5 percent, more than five times the 29.3 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 (HDHP/SO), are being offered with greater frequency.

Findings show increasingly that these plans have mixed results, and there are continued concerns about lack of affordability impacting access. 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 12, the Work Group met four times, with the last meeting on October 24. Jim Soos, DPH's Assistant Director of Policy and Planning, chaired the Work Group, and Patrick Chang of 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. Participants included representatives from both for-profit businesses and non-profit organizations, a practice that is consistent with recommendations 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 approved the recommendations in this report.

Of great assistance to the group for information and analysis about the health insurance market were brokers from two different firms, Valli Bowman of Chapman Insurance and Cecilia Paul of Shargel & Co. Insurance Services. These brokers provided information crucial to the process, answered the group's questions, and provided insight on 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 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, 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 19 Health Maintenance Organization (HMO) plans and 7 Preferred Provider Organization (PPO) plans, for a total of 26 plans all of which are compliant with the current (2011) Minimum Standards.

Given this review and analysis, three of the 12 Minimum Standards are recommended for change for 2013. Given the significant changes anticipated in the health insurance market in 2013 with the implementation of the Affordable Care Act (ACA) in 2014, the Work Group agreed to revisit the Minimum Standards in 2013. A summary of the Standards recommended for change and those recommended to remain the same is contained in the chart below. A side-by-side comparison of the 2011 Standards and the 2013 Recommended Standards is contained in Appendix A.

#	Benefit Requirements	Recommendation
1	**Type of Plan Required**	No Change
2	**Employee Premium Contribution**	No Change
3	**Annual Out-of-Pocket (OOP) Maximum**	No Change
4	**Prescription Drug Deductible**	Change
5	**Regular (Medical Services) Deductible**	Change
6	**Prescription Drug Coverage**	Change
7	**Coinsurance Percentages**	No Change
8	**Copay for Preventive Care Visits & Services**	No Change
9	**Copayments for Physician Office Visits for Primary Care, Perinatal/Maternity**	No Change
10	**Medical Services**	No Change
11	**Mental Health/Alcohol & Substance Abuse Services**	No Change
12	**Emergency Room Services & Ambulance**	No Change

The following points describe the current Minimum Standards and the recommendations for change:

1. **<u>Type of Plan Required</u>: Any type of plan that meets the Minimum Standards as described below.**

   In 2010, the Minimum Standards Work Group agreed that easing the requirement that employers offer only HMOs was necessary given the realities of the health insurance market. This component of the 2011 HCAO Minimum Standards was updated from previous versions that required employers to offer a HMO plan that met the revised minimum standards. Prior to 2010, HMOs were more affordable for employers and employees alike. There were cost savings in managing the population enrolled in these programs, but over time these cost savings have eroded somewhat and the premiums reflected this shift.

   Given these changes, employers in California have been moving beyond offering HMO plans to other types such as PPO, point of service (POS), and HDHP/SO plans. In 2011, 76 percent of California employees were offered an HMO and 77 percent were offered a PPO. Nationally, in 2011, employers were significantly more likely to offer a PPO (76 percent) rather than an HMO plan (39 percent).[1]

   It is recommended that we continue to allow any type of plan, as long as it adheres to the Minimum Standards in their entirety. This will allow more health plan options for employers to choose from, while preserving the best interests of workers.

   - **<u>Recommendation</u>: No Change – Any type of plan that meets the Minimum Standards as described below.**

2. **<u>Employee Premium Contribution</u>: 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 premium 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 between the employer and the employee. In fact, in 2011, 76 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 the HCAO are low-wage workers; a requirement that employees pay a portion of the premium may cause some employees to decline the coverage. (The HCAO requires employers to offer adequate coverage, but employees are not required to accept.) In California, the average monthly premium

[1] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2011.
[2] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2011.

for single coverage was $498 per month in 2011, and the average worker paid $757 annually for his/her share of the premium.[3]

On the other hand, there was a concern expressed that high premium costs have caused many employers, especially non-profit organizations (NPOs), to increase cost-sharing and/or discontinue family coverage for workers. Additionally, funding increasing costs of premiums has made it challenging for NPOs, in particular, to pay for wage increases and other operational expenses. Ultimately, the group decided that the priority of the HCAO has always been to protect workers.

- **Recommendation: No Change – The employer must pay 100% of the employee's health coverage premium.**

3. **Annual Out-of-Pocket Maximum: No higher than a $4,000 maximum, including all types of employee cost sharing (deductible, copayments, coinsurance, etc.).**

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 other cost-sharing cannot exceed the OOP maximum. The current annual OOP maximum in the HCAO's Minimum Standards is set at $4,000.

The recommendation is to retain the maximum amount in order to capture all possible cost-sharing variables. 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 simplifies and clarifies the requirements regarding the employee's cost sharing and ensures a fixed amount over which no employee's out-of-pocket health costs can go for the year.

- **Recommendation: No Change – No higher than a $4,000 maximum, including all types of employee cost sharing (deductible, copayments, coinsurance, etc.).**

4. **Prescription Drug Deductible: (In-Network) No higher than a $4,000 maximum, including all types of employee cost-sharing (deductible, copayments, coinsurance, etc.). (Out-of-Network) Not specified.**

Deductibles for both prescription drug and medical services (Minimum Standard 5) were the most controversial standards in the 2012 Work Group. Two years ago, the Work Group decided to add deductibles to the Minimum Standards for the first time. For the 2011 Minimum Standards, the amount was capped at $4,000 and included as part of the OOP maximum of $4,000. The Work Group felt that a $4,000 deductible

[3] California HealthCare Foundation, *California Employer Health Benefits Survey*, Dec. 2011.

was too high, particularly for plans without copayments not subject to the deductible or other mechanisms to provide first dollar coverage. Through the analysis of available plans in the small group market, it was clear that an array of available plans exists with lower prescription drug deductibles that would provide employers with a range of plan choices while protecting workers from excessive deductibles.

- **<u>Recommendation</u>: Change – (In-Network) No higher than a $300 maximum. (Out-of-Network) Not specified.**

5. **<u>Regular (Medical Services) Deductible</u>*:* No higher than a $4,000 maximum, including all types of employee cost-sharing (deductible, copayments, coinsurance, etc.).**

The Minimum Standards were first set at a time that deductibles were highly unusual in HMOs. Nationally, 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 by 2010. In 2009, deductibles were required for 77 percent of those with PPOs.[4] Two years ago, the Work Group decided to add deductibles to the Minimum Standards for the first time.

As noted in Minimum Standard 4, above, deductibles and the appropriate limit were the most controversial standards in the 2012 Work Group. Of the 26 small group plans that the Work Group reviewed, 21 (81%) included a medical service or prescription drug deductible or both as part of the cost sharing mechanism. Therefore eliminating deductibles as a form of cost sharing was simply not viable. The Work Group, however, believed that the current $4,000 deductible limit was too high, particularly for plans without copayments not subject to the deductible or other mechanisms to provide first dollar coverage. The following compromise was struck.

- **<u>Recommendation</u>: Change – (In-Network) No higher than a $2,000 maximum. If an employer offers a plan with a deductible higher than $2,000, the employer must fund a plan-compatible Health Reimbursement Account (HRA) or Health Savings Account (HSA) for the amount exceeding the $2,000 maximum deductible (e.g., employer-funded plan-compatible HRA or HSA of $500 for a plan with a $2,500 deductible). (Out-of-Network) Not specified.**

6. **<u>Prescription Drug Copayments</u>*:* Not specified. Coverage of non-formulary drugs not required.**

Most health insurance plans have moved to a four-level tiered copayment system for prescription drugs, with a low/no copayment for generic drugs, higher-cost generics,

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

brand-name drugs, and the highest for specialty drugs. The common practice is for plans to differentiate coverage between *formulary* and *non-formulary* drugs where these classifications are based on the carriers' definitions.

Because of variations in plan design and the recent introduction of plans that exclude coverage for name-brand drugs, the recommendation is that brand-name drugs be covered, but that we refrain from specifying restrictions or parameters on costs between generic versus brand-name drugs or between formulary and non-formulary drugs. By being general in language, it can best guarantee the most options and protect the best interest of workers. Additionally, the out-of-pocket maximum of $4,000 contained in Minimum Standard 3, above, includes all copayments and cost sharing. Thus, there is no need to specify a limit on prescription drug copayments.

- **<u>Recommendation</u>: Change – <u>Prescription Drug Coverage</u>: Must provide prescription drug coverage, including coverage of name-brand drugs.**

7. **<u>Coinsurance amounts</u>: 20% in-network / 50% out-of-network.**

Much like deductibles, coinsurance was traditionally associated with PPOs, but has become a more common 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. Of the 26 small group plans reviewed by the Work Group, seven (27%) include coinsurance as a cost sharing mechanism.

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 on the worker. Given the various types of plans allowed 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 is still adequate to ensure availability of compliant plans for employers. As with other cost sharing mechanisms, coinsurance would be subject to the $4,000 annual out-of-pocket maximum (Minimum Standard 3). This will protect workers from plans that exclude these payments from OOP maximums, meaning that there is no point at which the worker would be required to spend more than $4,000 out of pocket per year for medical services.

- **<u>Recommendation</u>: No Change – 20% in-network/50% out-of-network**

8. **<u>Copayment for Preventive Care Visits and Services</u>: 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 plan's out-of-network requirements.**

Federal 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 federal law under the ACA.

- **<u>Recommendation</u>: No Change – 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 plan's out-of-network requirements.**

9. <u>Copayment for Physician Office Visits (primary care and prenatal/maternity)</u>: $30 maximum.

The majority of health plans, regardless of type, require an office visit copayment of $30 or under. This was true two years ago, and remains true today.

- **<u>Recommendation</u>: No change – $30 maximum.**

10-12. <u>The noted following services must be covered, but associated copayments amounts are not specified. 20% in-network/50% out-of-network coinsurance amounts apply. For emergency services, in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.</u>

- 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
- Emergency services and ambulance

Due to changes made effective through health reform, emergency medical services 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. In 2010, it was decided that the Minimum Standards should go one step further and not allow the exception for grandfathered plans.

It is a priority to DPH to ensure that the health benefit coverage offered to employees subject to the 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 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 employees, protecting them from paying too much in case of major health event, or an expensive chronic condition.

- **Recommendation: No Change – Maintain the existing list of covered, but not specify the associated copayments amounts. 20% in-network/50% out-of-network coinsurance amounts apply. For emergency services, in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.**

Section D: 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, health, and productivity of the workforce on the City's contracts and leases. While the ACA 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. Rather than wait another two years, the Work Group agreed to reconvene in 2013 in anticipation of the broader implementation of the ACA in January 2014 to assess changes that may be necessary at that time.

The attached draft resolution (Attachment C) requests approval to revise the Minimum Standards effective January 1, 2013. These new Standards meet the goals set for and represent the consensus of the HCAO Minimum Standards Work Group. They protect employees from inordinate cost increases by keeping the copayment maximum at the same amount, lowering the prescription drug and medical deductible maximums while giving employers flexibility, retaining the comprehensive benefits list, capping the coinsurance at an amount that is at the average for small business plans, and combining the cost-sharing amounts into one overall maximum for the year. In addition, the flexibility allows employers to have a choice among compliant plans.

Health Care Accountability Ordinance:
Recommendations for New Minimum Standards

#	Benefit Requirements	Current Minimum Standards (2011)	Recommendations for 2013
1	**Type of Plan Required**	Any type of plan that meets the Minimum Standards as described below.	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**	In-Network: No higher than a $4,000 maximum, including all types of employee cost-sharing (deductible, copayments, coinsurance, etc.). Out-of-Network: Not specified.	In-Network: No higher than a $4,000 maximum, including all types of employee cost-sharing (deductible, copayments, coinsurance, etc.). Out-of-Network: Not specified.
4	**Prescription Drug Deductible**	In-Network: No higher than a $4,000 maximum, including all types of employee cost-sharing (deductible, copayments, coinsurance, etc.). Out-of-Network: Not specified.	In-Network: No higher than a $300 maximum. Out-of-Network: Not specified.
5	**Regular (Medical Services) Deductible**	In-Network: No higher than a $4,000 maximum, including all types of employee cost-sharing (deductible, copayments, coinsurance, etc.). Out-of-Network: Not specified.	In-Network: No higher than a $2,000 maximum. If an employer offers a plan with a deductible higher than $2,000, the employer must fund a plan-compatible Health Reimbursement Account (HRA) or Health Savings Account (HSA) for the amount exceeding the $2,000 maximum deductible (e.g., employer-funded plan-compatible HRA or HSA of $500 for a plan with a $2,500 deductible).

#	Benefit Requirements	Current Minimum Standards (2011)	Recommendations for 2013
			Out-of-Network: Not specified.
6	**Prescription Drug ~~Copayments~~ Coverage**	Not specified. Coverage of non-formulary drugs not required.	Must provide prescription drug coverage, including coverage of name-brand drugs.
7	**Coinsurance Percentages**	20% in-network 50% out-of-network	20% in-network 50% out-of-network
8	**Copay for Preventive Care Visits & Services**[5]	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 plan's out-of-network requirements.	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 plan's out-of-network requirements.
9	**Copayments for Physician Office Visits for Primary Care, Perinatal/Maternity**	$30 maximum. Out-of-Network: Not specified.	$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**	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.	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 Minimum Standards (2011)	Recommendations for 2013
	• **Cancer clinical trials** • **Outpatient diagnostic services (x-ray, labs, etc.)** • **Perinatal and maternity care, including delivery services and 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. When coinsurance is applied to services: 20% in-network 50% out-of-network When copayments are applied for these services: 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
12	**Emergency Room Services & Ambulance**	Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.	Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.

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Health Care Accountability Work Group List of Invitees/Attendees

Organization	Name	Attended Meeting(s)
Chapman Insurance	Valli Bowman	Yes
Compass Family Services	Wendy Emerson	Yes
Dolores St Community Center	Mason Jeffrys	Yes
DPH – OPP	Colleen Chawla Jim Soos Patrick Chang	Yes
Enterprise Rent a Car	David Chopp	Yes
Human Services Network	Debbi Lerman	Yes
IHSS Consortium	Michael Meic	Yes
Local 3, AFL-CIO	Conny Ford	Yes
OLSE-Compliance	Richard Waller Donna Mandel	Yes
RAMS	Trina Dejoya	Yes
SF Labor Council • SEIU 1021 • Unite Here, Local 2 • SEIU-USWW • IBT-856	Tim Paulson David Fleming Cristal Java Ian Lewis Jamie Thompson Mike Lagomarsino	Yes
SF Living Wage Coalition	Karl Kramer	Yes
SFO	Bill Wong	Yes
Shargel & Co. Insurance	Cecilia Paul	Yes
Sodexo, Inc.	David Simpson	No

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 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 September 2012, DPH convened the Minimum Standards Work Group, with representatives from various entities including health insurance broker firms, employers, labor, 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 there was consensus on the revisions to the Minimum Standards, as detailed herein, that would 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 Work Group agreed to meet again in 2013 to reconsider the Minimum Standards for 2014 in light of the changes anticipated in the health insurance market with broader implementation of the federal Affordable Care Act (ACA); and

WHEREAS, With the help of the Work Group's guidance, DPH produced a written report presented to the Health Commission on November 6, 2012, with an explanation of the process and description of the recommendations; and

WHEREAS, DPH supports the proposal developed by the HCAO Minimum Standards Work Group, as described fully in Attachment A to this resolution, and is respectfully requesting approval from the Health Commission; THEREFORE, BE IT

RESOLVED, that the Health Commission approves the revised Minimum Standards effective January 1, 2013 for the calendar year 2013, as detailed in Attachment A to this resolution; and be it

FURTHER RESOLVED, that the Health Commission supports the Work Group's reconsideration of the Minimum Standards in 2013 to ensure compliance with the ACA.