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 19th, 2022

To: Dan Bernal, 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, Health Program Planner, Office of Policy and Planning
Michele Ko, Intern, Office of Policy and Planning

Re: Health Care Accountability Ordinance – Suggested Revisions to the Minimum Standards for 2023 and 2024

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 made by the HCAO Minimum Standards Workgroup convened by DPH (Attachment C).

We respectfully request that you consider the workgroup's recommendations, summarized in Attachment B to this report, and look forward to discussing the findings with the members of the Health Commission on July 19, 2022. 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 the not at the San Francisco Airport (SFO), or the San Bruno Jail. For FY22-23, the fee is $6.10 per hour worked per employee up to $244 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 2020, and went into effect on January 1, 2021. Since 2004, it has been DPH's practice to convene a workgroup of stakeholders representative of 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

[1] Office of Labor Standards & Enforcement (2022). Retrieved from https://sfgov.org/olse/health-care-accountability-ordinance-hcao

the standards are workable for a full two years. It is common for health insurers to modify plan design from year-to-year, sometimes significantly. Additionally, the health care environment continues to face significant uncertainty as a result of the global COVID-19 pandemic's impact on healthcare utilization and delivery along with record breaking inflationary pressures. It is important that both employers and employees have affordable plans to choose from.

A. The HCAO Workgroup

Starting on May 19, 2022, the workgroup met four times, with the last meeting on June 23, 2022. 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. 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 workgroup's membership can be found in Attachment C. All members of the workgroup reviewed and accepted 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. Many individuals avoid or delay medical care over concerns of high costs or medical debt. Half of U.S. adults say they put off or skipped some sort of health care or dental care in the past year because of the cost. Three in ten U.S. adults report not taking their medicines as prescribed at some point in the past year because of cost.[4] Those who reported problems paying for medical bills also reported having to cut spending on necessities or household purchases and use up all or most of their savings as a result.[5] Extensive research shows that delaying medical care is not only detrimental to a patient's health, but it can also be financially damaging. As health conditions escalate, it can lead to more complicated surgeries, 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. The Center for Medicare and Medicaid Services (CMS) projects that the annual growth in national health spending is expected to average 5.1% over 2021-2030, and to reach nearly $6.8 trillion by 2030. Growth in the nation's Gross Domestic Product (GDP) is also projected to be 5.1% annually over the same period, with the health share of GDP expected to be 19.6% in 2030.[7]

Premium and out-of-pocket medical expenses continue to rise and contribute to affordability concerns. The average single and family premiums increased 4% over 2021. During this period, workers' wages increased 5% and inflation increased 1.9%. The average premium for family coverage has increased 22% over the last five years and 47% over the last ten years.[8] For employer-based coverage in 2021, the average deductibles for single coverage were $2,379 for covered workers at small firms and $1,397 for covered workers in larger firms.[9] From 2010 -2020, average family premiums have increased 55%, at least twice as fast as wages (27%) and inflation

[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] Kearney, A. et al. (2021), Americans' Challenges with Health Care Costs, Retrieved from https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/
[5] Kearney, A. et al. (2021), Americans' Challenges with Health Care Costs, Retrieved from https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/
[6] Prentice, J. C., & Pizer, S. D. (2007). Delayed Access to Health Care and Mortality. Health Services Research, 42(2), 644–662.
[7] Center for Medicare and Medicaid Services (2022), CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures, Retrieved from https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2021-2030-projections-national-health-expenditures
[8] Kaiser-Family Foundation (2021), 2021 Employer Health Benefits Survey, Retrieved from https://www.kff.org/report-section/ehbs-2021-summary-of-findings/
[9] Peterson-Kaiser Health System Tracker (2022), Many households do not have enough money to pay cost-sharing in typical private health plans, Retrieved from https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/

(19%).[10] In California, in the past year, 14% of California firms reported that they increased cost sharing for their workers, and 24% of California firms stated they are "very likely" to increase the amount workers pay for premiums in 2022.[11]

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. Nearly half of insured adults report difficulty affording their out-of-pocket costs, and one in four report difficulty affording their deductible.[12] Almost 1 in 2 adults worry about their ability to pay medical bills if they get sick or have an accident.[13] People in lower-income families with employer coverage are disproportionately impacted, spending a greater share of their income on health costs than those with higher incomes.[14]

D. COVID-19 Impact on health care trends.

In 2020, annual national health expenditures increased by 9.7%, driven in large part by federal spending in response to the pandemic. Despite the overall rise, private insurance and out-of-pocket spending on health care dropped for the first time in recorded history in 2020, indicating decreased health care utilization.[15]

Healthcare utilization significantly decreased after the onset of COVID-19 and has yet to fully rebound. In 2020, health spending was down 18% in the second quarter of 2020 and continued to decrease through the rest of the year.[16-17] Early 2021 data shows healthcare utilization lower than expected, with hospital admissions remaining below expected levels through early April 2021 and health spending for hospitals and ambulatory care remaining below expected levels through June 2021. Further, there has not been an increase in hospital admissions due to pent-up demand for forgone care in the last year.[18]

In California, the insured rate hit a record high during the first year of the pandemic, with 94% of Californians currently insured in 2020.[19] Several factors, including the full implementation of the Affordable Care Act in 2014, statewide policies to expand coverage, and federal policies enacted during the pandemic, protected coverage for many Californians. Between 2019 and 2020, employer and individual coverage held steady statewide and increased for some groups.[20] California saw steady increases in Medi-Cal enrollment since April 2020, with caseloads about 9% larger in January 2021 compared to January 2020.[21] Local data on San

[10] Kaiser-Family Foundation (2020), Average Family Premiums Rose 4% to $21,342 in 2020, Benchmark KFF Employer Health Benefit Survey Finds, Retrieved from https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-to-21342-in-2020-benchmark-kff-employer-health-benefit-survey-finds/

[11] Whitmore, H. et al. (2021), 2021 Edition - California Employer Health Benefits, California Healthcare Foundation, Retrieved from https://www.chcf.org/publication/2021-edition-california-employer-health-benefits/

[12] Kearney, A. et al. (2021), Americans' Challenges with Health Care Costs, Retrieved from https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/

[13] Peterson-Kaiser Health System Tracker (2022), How does cost affect access to care? Retrieved from https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/

[14] Claxton, G. et al. (2022), How Affordability of Health Care Varies by Income among People with Employer Coverage, Kaiser Family Foundation, https://www.kff.org/health-costs/issue-brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/

[15] Lane, K. et al. (2022), Tracking the Pandemic's Effect on Health Outcomes, Costs, and Access to Care, Health Affairs, Retrieved from https://www.healthaffairs.org/do/10.1377/forefront.20220201.857067

[16] Peterson-Kaiser Health Systems Tracker (2021), How have health spending and utilization changed during the corona virus pandemic?, Retrieved from https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/

[17] Legislative Analyst's Office (2021), Impact of COVID on Healthcare Access, Retrieved from https://lao.ca.gov/Publications/Report/4426; The Household Pulse Survey, conducted by the Census Bureau, is a 20-minute online survey designed to measure the impact COVID has on households across the country. Data collection began on April 23, 2020 and currently follows a two-weeks on, two-weeks off collection and dissemination approach. A limited number of addresses from across the country are scientifically selected to represent the entire population. https://www.census.gov/programs-surveys/household-pulse-survey.html

[18] Peterson-Kaiser Health Systems Tracker (2021), Early 2021 data show no rebound in heatlh care utilization, Retrieved from https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization

[19] Tan, S. (2021), California Reached Health Coverage Milestone with 94% of People Insured in 2020, but Access to Care Remains a Challenge During COVID-19 Pandemic, UCLA Center for Health Policy Research, https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=2210; California Healthcare Foundation (2022), Coverage During a Crisis: Insured Rate for Californians Hits Historic High in First Year of COVID-19 Pandemic, Retrieved from https://www.chcf.org/wp-content/uploads/2022/01/CoverageDuringCrisisInsuredRateHistoric-HighPandemic.pdf.

[20] California Healthcare Foundation (2022), Coverage During a Crisis: Insured Rate for Californians Hits Historic High in First Year of COVID-19 Pandemic, Retrieved from https://www.chcf.org/wp-content/uploads/2022/01/CoverageDuringCrisisInsuredRateHistoric-HighPandemic.pdf.

[21] Public Policy Institute of California (2022), Health Care Reform in California, https://www.ppic.org/publication/health-care-reform-in-california/

Francisco health coverage is only available for pre-pandemic years.

Federal polices to promote access and affordability during the pandemic have an uncertain future. During the pandemic, federal emergency declarations, and legislation tied to them, paved the way for increased access and affordability to healthcare for many communities. Questions remain around which provisions will be extended or made permanent, and which will expire, as changes will have significant implications for our healthcare system.[22]

E. Health Plan Review

The workgroup evaluated 165 small group health plans from Q3 2022 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.

TABLE 1: Summary of Plans Analyzed by 2022 Workgroup

Carrier	Bronze	Silver	Gold	Platinum	Total
Aetna	5	6	10	3	24
Anthem Blue Cross	7	8	12	6	33
Blue Shield	7	7	9	7	30
Chinese Community Health Plan	2	3	2	4	11
Health Net	2	5	12	3	22
Kaiser	3	5	5	2	15
Sutter Health Plans	2	2	3	2	9
United Healthcare	3	4	8	6	21
Total	**31**	**40**	**61**	**33**	**165**

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 only gold- and platinum-level plans on the marketplace are compliant with the current Minimum Standards. With interest in expanding the 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 workgroup recommends the following revisions 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.
- Institute a new framework that dramatically increases the availability of compliant silver plans while reducing the overall cost responsibility for employees. Under this framework:
  - Employers should be required to cover up to 50% of the plan's out-of-pocket limit, while the deductible coverage requirement should be removed.
  - Cost sharing limits for co-insurance and primary care co-payments should be adjusted to allow for a significant increase in silver plan availability.

Attachment B provides a side-by-side comparison of the current Standards and the workgroup's recommendations. The following section describes the recommendations and their rationale.

[22] Cubanski, J. et al. (2022), What Happens When COVID-19 Emergency Declarations End? Implications for Coverage, Costs, and Access, Kaiser Family Foundation, https://www.kff.org/coronavirus-covid-19/issue-brief/what-happens-when-covid-19-emergency-declarations-end-implications-for-coverage-costs-and-access/#coverage-costs-and-payment

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 monthly health insurance premium in California in 2020, including the employer contribution, was $653 for single coverage and $1,717 for family coverage. In 2020, overall premiums increased by 3.5% from the previous year.[23] Given that all types of health care costs continue to rise, the consensus recommendation is to retain the current Minimum Standard to preserve the intent of the HCAO and to best ensure employees' access to affordable health coverage.

Recommendation: Retain current Minimum Standard.

Minimum Standard 2: Annual Out-of-Pocket Maximum

- ***In-Network:*** *California Patient-Centered Benefit Design* out-of-pocket limit for a silver coinsurance or copay plan during the plan's effective date.
- ***Out-of-Network:*** *Not specified.*

Nearly all health insurance plans set a specific out-of-pocket (OOP) maximum, which limits the insured's financial liability for the plan year. The amount an insured person pays during the year in deductibles, coinsurance, copayments, and other cost-sharing cannot exceed the OOP maximum.

The workgroup sought a solution that would significantly increase the number of compliant silver plans while decreasing the OOP expenses to employees. With this goal in mind. the workgroup recommended requiring employers 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, 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 Maximum.

On average, under this recommended standard, employers will be responsible for up $4,040 of OOP expenses if they choose a silver plan for their employees compared to $2,193 under the previous standard. With these increased cost responsibilities, the group recommended adjusting the Co-Insurance Minimum Standard for in-network services to 60%/40%, and Copayment Minimum Standard to $60 per visit, or if co-insurance is provided, to no more than 40%. Adjusting the standards to these levels would increase to percentage of compliant silver plans from 5% to 75% based on the available Q3 2022 small group plans. Employer representatives emphasized that, despite the increases in their cost responsibility, the greater availability in silver plans is highly desirable and allows greater flexibility to tailor health plans to their staff makeup and needs.

While employers will have increased cost responsibility under the new standards, workgroup members voiced strong concern about the increases in copays and coinsurances if employees must pay for these expenses upfront while waiting for reimbursement. If it was feasible to do so, there was strong interest across all workgroup members to require employers to provide an employer-funded mechanism (i.e., prefunded debit card) to beneficiaries to ease their reimbursement process. Upon an examination of health benefit landscape, as well a review of HCAO workgroup minutes from the previous six years, it was concluded that this requirement would be challenging to implement through the HCAO standards at this time for the following reasons:

- Requirement could result in cash flow issues for organizations if they are required to fully fund a health savings/reimbursement product to cover 50% of the plan's out-of-pocket expenses. In 2016, the HCAO standards were revised to require that employers cover 100% of the medical deductible with a fully employer-funded HSA or HRA. The requirement to fully fund these savings/reimbursement products was removed in 2018 given the significant complications it had created for employers.
- Requiring an employer-funded mechanism could create an additional layer of complexity to employers in complying with the standards, as well as additional cost.

Overall, seven (7) out of eight (8) workgroup members agreed to accept the recommendation for these standards. If the employer-funded mechanism was available as described, all workgroup members would have endorsed the recommended changes.

[23] California Healthcare Foundation, 2021 CA Employer Health Benefits, Retrieved from https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf

In lieu of requiring employers to use an employer funded mechanism to cover OOP expenses upfront, DPH will include a strong recommendation in the guidelines adjoining the standards that an employer-funded mechanism, like a pre-funded debit card, be provided to beneficiaries to cover out-of-pocket expenses, such as copay, upfront.

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 state benchmark provides greater predictability for employers to anticipate and prepare for subsequent plan years while allowing them to access a larger number of plans. The workgroup determined that the OOP maximum should remain synced to the PCBD.

Recommendation:
- Revise 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 remain synced to the California Patient-Centered Benefit Design (PCBD) OOP limit for silver coinsurance or copay plans.

Minimum Standard 3: Medical Services Deductible

- ***In-Network:*** *No higher than a $3,000 maximum.*

  The employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard.

- ***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, 81% of plans had a medical deductible of $3,000 or less, with the breakdown of 0 Bronze plans, 40 Silver plans, 61 Gold plans, 33 Platinum plans. The workgroup determined that given the decision to require employers cover OOP expenses up to 50% of the plan's OOP Maximum, the deductible coverage requirement should be removed. On average, silver plan deductibles represent 28% of out-of-pocket costs, and therefore will still be effectively covered by the employer under the new OOP standard in most situations.

Note, that the deductible limit is still set to $3,000, and for Platinum and Gold plans to be automatically compliant, employers must still fully cover the deductible.

Recommendation: Revise Minimum Standard to remove deductible coverage requirement.

Minimum Standard 6: Coinsurance Percentages

- ***In-Network:*** *80% / 20%*
- ***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. Under the ACA, the use of metal tiers to standardize a plan's actuarial value translates to health plans covering 60% of costs for bronze, 70% for silver, 80% for gold, and 90% for platinum. As a result, within each tier, a lower deductible will correspond with higher OOP costs in the form of coinsurance and copayments. The relationship is consistent across cost-sharing where a lower value for one relates to a higher value for another.

The workgroup evaluated maintaining the standard at 80%/20%, which would lessen the financial burden on employees, yet may render the option to purchase silver plans obsolete. This would be a major issue for smaller non-profit organizations already struggling with sustainability issues. Of the plans analyzed, coinsurance at or below 20% includes only two silver plans, at or below 30% would include 10 silver plans, and at or below 30% would include 34 silver plans. Silver plans increasingly are adopting higher coinsurance levels that make maintaining the current standard untenable for allowing compliant silver plans.

The workgroup agreed that given the decision to require employers cover OOP expenses up to 50% of the plan's OOP Maximum, the coinsurance rates should be increased to 60%/40% for in-network services.

Recommendation: Revise Minimum Standard to set Coinsurance at 60%/40% for in-network services.

Minimum Standard 7: Copayment for Primary Care Provider Visits

- ***In-Network:*** *$50 per visit*
- ***Out-of-Network:*** *Not specified*

A copayment is a fixed amount the consumer pays for a covered healthcare service after the deductible is met. Of the plans analyzed, 76% of plans have a copayment at or below the current HCAO limit of $50. These plans include 8 Bronze, 15 Silver, 58 Gold, and 33 Platinum.

The workgroup determined that given the decision to require employers cover a percentage of the OOP Maximum, copayments should be increased to $60 per visit, or if a coinsurance is provided instead, that it be no greater than 40%.

Workgroup members emphasized their concern that copayment amounts are cost prohibitive to many low-income works seeking healthcare, and it is not financially feasible to expect employees to pay costs upfront. Members evaluated the possibility of requiring employers provide an "employer-funded" mechanism, such as a pre-paid debt card, for employees to use for OOP costs. The workgroup strongly encourages employers to explore such mechanisms, and the adjoining guidelines to the minimum standards will include this recommendation as well.

Recommendation: Revise Minimum Standard to set copayment for in-network at $60 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 3% to $348.4 billion in 2020, slower than the 4.3% growth in 2019.[24] Spending growth for retail prescription drugs is projected to increase over 2021-2030 at an average rate of 5%.[25] Similar to a deductible for medical services, some plans include a prescription drug deductible, which is the amount a consumer must pay for covered prescription drugs before the insurance plan begins to pay. The workgroup found that the $300 maximum is not a barrier to availability of silver plans and reached consensus to maintain the standard with no revisions.

Recommendation: Retain current Minimum Standard.

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 2020, 53% of California workers with coverage had a three- or four-tier cost-sharing formula for prescription drugs, compared to 83% nationally. The share of California workers with four tiers has increased substantially over time, from 4% in 2012 to 20% in 2020.[26] 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.

[24] Center for Medicare and Medicaid Services, NHE Fact Sheet, Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

[25] Center for Medicare and Medicaid Services (2022), CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures, Retrieved from https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2021-2030-projections-national-health-expenditures

[26] California Healthcare Foundation, 2021 CA Employer Health Benefits, Retrieved from https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf

IV: Other Items

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

A. Funding for Non-Profits

Workgroup members raised serious concern 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 the city's non-profit sector is facing rising costs of doing business, healthcare costs, and costs of living, in addition to new and unprecedent inflationary pressures without commensurate CCSF budget allocations to offset these forces. Members expressed that this dynamic creates significant challenges to these organizations to provide affordable and comprehensive health coverage to their employees.

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 these recommendations represent the consensus of its members.

With these recommendations, the Minimum Standards will:

- Continue to allow all gold- and platinum-level plans automatic compliance if premium and deductible fully covered;
- Institute a new framework that significantly increases the availability of compliant 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 60%/40%
    - Copayment for PCP visits revised to $60, or if coinsurance is provided, no more than 40%.

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, 2023.

Recommendations for New Minimum Standards, 2023-2024

The following summarizes the workgroup's review and recommendations for the Minimum Standards effective January 1, 2023 through December 31, 2024. A health plan must meet all 16 minimum standards to be deemed compliant.

Benefit Requirement	Current Minimum Standard (2021-22)	Recommended Revision (2023-22)
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, but revise language regarding reference to funding requirements. • Language will be added to specifically indicate employers must fully cover the plan's premium and medical deductible in order for gold and platinum plans to be automatically compliant.
1. Premium Contribution	Employer pays 100%.	**Recommendation:** Retain current Minimum Standard.
2. Annual Out-of-Pocket Maximum	• ***In-Network***: *California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan's effective date. No higher than $8,200 max.* • ***Out-of-Network***: *Not specified* *OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.)*	**Recommendation**: • Revise Minimum Standard to require employer cover in-network out-of-pocket expenses up to 50% 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.). • OOP Maximum will remain synced to the California Patient-centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan.
3. Regular (Medical Services) Deductible	• ***In-Network***: *$3,000 max.* • ***Out-of-Network***: *Not specified* *The employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard.*	**Recommendation**: • Revise Minimum Standard to remove deductible coverage requirement.

Benefit Requirement	Current Minimum Standard (2021-22)	Recommended Revision (2023-22)
4. Prescription Drug Deductible	• ***In-Network:*** *$300 max.* • ***Out-of-Network:*** *Not specified*	**Recommendation:** Retain current Minimum Standard.
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:*** *80%/20%* • ***Out-of-Network:*** *50%/50%*	**Recommendation:** • Revise Minimum Standard to set Coinsurance for in-network to 60%/40%.
7. Copayment for Primary Care Provider Visits	• ***In-Network:*** *$50 per visit* • ***Out-of-Network:*** *Not specified*	**Recommendation:** • Revise Minimum Standard to set copayment for in-network at $60 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:*	**Recommendation:** Retain current Minimum Standard.

Benefit Requirement	Current Minimum Standard (2021-22)	Recommended Revision (2023-22)
	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	**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 2022 Members

Name	Organization
Beverly Popek	Office of Labor Standards and Enforcement
Jane Bosio	OPEIU 29
Cynthia Gomez	Unite Here, Local 2
Debbi Lerman	SF Human Services Network
Tina de Joya	RAMS, Inc.
Kris Narahara	RAMS, Inc.
Kim Tavaglione	SF Labor Council (SFLC)
Karl Kramer	SF Living Wage Coalition
Lynn Jones	EPIC
Felicia Houston	Community Forward SF
Lici Huang	Self-Help for the Elderly
Larry Loo	Chinese Community Health Plan (CCHP)
Wil Yu	CCHP
Bill Wong	SFO

Health Commission
City and County of San Francisco
Resolution No.

AMENDING THE HEALTHCARE ACCOUNTABILITY ORDINANCE MINIMUM STANDARDS

WHEREAS, On July 1, 2001, the Healthcare Accountability Ordinance (HCAO) went into effect, requiring that employers doing business with the City provide health insurance coverage for their employees that meets all the Minimum Standards or pay a fee to offset costs for health care provided by the City and County of San Francisco to the uninsured; and

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

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

WHEREAS, In May 2022, DPH convened the Minimum Standards Workgroup, with representatives from various entities including health insurance broker firms, health plans, employers, labor advocates, and others, with the task of making recommendations for a revised set of Minimum Standards; and

WHEREAS, This workgroup met four times with the purpose of reviewing and making recommendations for changes to the Minimum Standards, with the goal to balance the needs of employers and employees that would ensure health insurance plan options for employers, retain comprehensive benefits for employees, and consider affordability for both; and

WHEREAS, The workgroup recognizes the financial challenges experienced by both employers and employees during this global pandemic and subsequent economic crisis; and

WHEREAS, The workgroup emphasizes the importance of maintaining access to affordable and comprehensive care for employees, while ensuring that employers have access to quality health plans for their staff; and

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

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

WHEREAS, DPH supports the proposal developed in conjunction with the HCAO Minimum Standards Workgroup, as described fully in this resolution, and is respectfully requesting approval from the Health Commission;

THEREFORE, BE IT RESOLVED, That the Health Commission thanks the Minimum Standards Workgroup for its thorough and thoughtful engagement and collaboration to develop recommended changes to the HCAO Minimum Standards for the Health Commission's consideration; and be it

FURTHER RESOLVED, That the Health Commission approves the following revised Minimum Standards effective January 1 for the calendar years 2023 and 2024:

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

Benefit Requirement	New Minimum Standard
	• Out-of-Network: Not specified
8. Preventive & Wellness Services	• In-Network: Provided at no cost, per ACA rules. • Out-of-Network: Subject to the plan's out-of-network fee requirements. These services are standardized by federal ACA rules at no charge to the member. The California EHB Benchmark Plan outlines the types of preventive services that are required.
9. Pre/Post-Natal Care	• In-Network: Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules. • Out-of-Network: Subject to the plan's out-of-network fee requirements. These services are standardized by federal ACA rules at no charge to the member. The California EHB Benchmark Plan outlines the types of pre- and post-natal services that are required.
10. Ambulatory Patient Services (Outpatient Care)	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: • Primary Care Provider: See Benefit Requirement #7 • Specialty visits: Not specified
11. Hospitalization	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified
12. Mental Health & Substance Use Disorder Services, including Behavioral Health	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified
13. Rehabilitative & Habilitative Services	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified
14. Laboratory Services	• When coinsurance is applied See Benefit Requirement #6 • When copayments are applied for these services: Not specified
15. Emergency Room Services & Ambulance	Limited to treatment of medical emergencies. The in-network deductible, copayment, and coinsurance also apply to emergency services received from an out-of-network provider.
16. Other Services	The full set of covered benefits is defined by the California EHB Benchmark plan.

I hereby certify that the San Francisco Health Commission adopted this resolution at its meeting of July 19, 2022._____

Mark Morewitz, MSW
Health Commission Executive Secretary