WHO IS A COVERED EMPLOYER?

A company that has:

• An City Contract with an HCAO Requirement/Provision
• 20 or more employees, anywhere in the world.

Keep in Mind:
It doesn’t matter where the company has it’s headquarters
WHO IS A COVERED EMPLOYEE?

Covered Employee:
• Anyone who works at least 20 hours a week or more on a City Contract for services.
• Not covered under Prevailing Wage.

Keep in Mind:
• A worker is covered if they are performing work anywhere in the US
• Work hours that fluctuate from week to week are Covered Employees if the average number of hours per week during applicable month is 20 hours or more.
Employer must choose **one** option that fits employee and location.

**Option 1**
Offer each covered employee a compliant health plan at no charge to the employee - no later than the first of the month after 30 days.
HCAO REQUIREMENTS

Option 2

Pay $5.15 per employee per hour to SF General Hospital

• **Rate adjusted every July 1**
• Fee goes to SF General Hospital
• Not a benefit or $ for worker (this is NOT Healthy San Francisco)
HCAO REQUIREMENTS

Option 3

Pay an additional $5.15 per hour directly to employee (only available to employees NOT working in SF, SFO, and San Bruno Jail).
OTHER HCAO REQUIREMENTS

• Annual Posters

• Annual HCAO Know Your Rights Forms

• HCAO Fee Payment Form on website: www.sfgov.org/olse/hcao

• All posters and forms are on our website: www.sfgov.org/olse/hcao

• HCAO Video: tinyurl.com/sfhcao
Beverly Popek
Compliance Officer
Office of Labor Standards Enforcement

beverly.popek@sfgov.org
(415) 554-6238
2019-2020
MINIMUM STANDARDS
CITY DEPARTMENT ROLES

MINIMUM STANDARDS

- Updates Minimum Standards
- Reviews health plan compliance

HEALTH COMMISSION
SFDPH

ENFORCEMENT

- Audits employers
- Responds to worker complaints
- Negotiates settlements
- Coordinates payment plans

OLSE

EMPLOYER
July 1, 2001

Employers provide health insurance that meets the Minimum Standards or pay a fee to DPH

City & County of SF contractors & lease holders

A compliant health plan must meet all of the standards, and they are reviewed/updated at least every 2 years

The Health Commission has sole authority to revise the Minimum Standards
MINIMUM STANDARDS

JAN 1, 2019 – DEC 31, 2020

16

COST-SHARING

PREMIUMS

REQUIRED SERVICES

1

5

10
A HEALTH PLAN MUST SATISFY **ALL** MINIMUM STANDARDS IN ORDER TO BE COMPLIANT.
# BENEFIT REQUIREMENT | MINIMUM STANDARD | CHANGES FROM 2017-2018
---|---|---
1 PREMIUM CONTRIBUTION | Employer pays 100% | NONE

2 ANNUAL OOP MAXIMUM
- In-Network: $7,550 for 2019
- Out-of-Network: Not specified
OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.).

3 REGULAR DEDUCTIBLE (MEDICAL SERVICES)
- In-Network: $2,000
- 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.

SYNC TO STATE BENCHMARK

NONE
<table>
<thead>
<tr>
<th>#</th>
<th>BENEFIT REQUIREMENT</th>
<th>MINIMUM STANDARD</th>
<th>CHANGES FROM 2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>PRESCRIPTION DRUG DEDUCTIBLE</td>
<td>• In-Network: $200</td>
<td>FROM $250</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-Network: Not specified</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>PRESCRIPTION DRUG COVERAGE</td>
<td>Plan must provide drug coverage, including coverage of brand-name drugs.</td>
<td>NONE</td>
</tr>
<tr>
<td>6</td>
<td>COINSURANCE PERCENTAGES</td>
<td>• In-Network: 80% / 20%</td>
<td>FROM 70%/30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-Network: 50% / 50%</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>COPAYMENT FOR PRIMARY CARE PROVIDER VISITS</td>
<td>• In-Network: $45 per visit.</td>
<td>NONE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-Network: Not specified</td>
<td></td>
</tr>
</tbody>
</table>
# MINIMUM STANDARDS (2019-2020)

<table>
<thead>
<tr>
<th>#</th>
<th>BENEFIT REQUIREMENT</th>
<th>MINIMUM STANDARD</th>
<th>CHANGES FROM 2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>AMBULATORY PATIENT SERVICES (OUTPATIENT CARE)</td>
<td>• When coinsurance is applied See Benefit Requirement #6</td>
<td>NONE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• When copayments are applied for these services:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Primary Care Provider: See Benefit Requirement #7</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Specialty visits: Not specified</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>PREVENTIVE &amp; WELLNESS SERVICES*</td>
<td>• In-Network: Provided at no cost, per ACA rules.</td>
<td>NONE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-Network: Subject to the plan’s out-of-network fee requirements.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>PRE/POST-NATAL CARE*</td>
<td>• In-Network: Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules.</td>
<td>NONE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-Network: Subject to the plan’s out-of-network fee requirements.</td>
<td></td>
</tr>
</tbody>
</table>

* Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.
<table>
<thead>
<tr>
<th>#</th>
<th>BENEFIT REQUIREMENT</th>
<th>MINIMUM STANDARD</th>
<th>CHANGES FROM 2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>HOSPITALIZATION*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When coinsurance is applied See Benefit Requirement #6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When copayments are applied for these services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not specified</td>
<td></td>
<td>NONE</td>
</tr>
<tr>
<td>13</td>
<td>REHABILITATIVE &amp; HABILITATIVE SERVICES*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>LABORATORY SERVICES*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.
## MINIMUM STANDARDS (2019-2020)

<table>
<thead>
<tr>
<th>#</th>
<th>BENEFIT REQUIREMENT</th>
<th>MINIMUM STANDARD</th>
<th>CHANGES FROM 2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>EMERGENCY ROOM SERVICES &amp; AMBULANCE*</td>
<td>Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.</td>
<td>NONE</td>
</tr>
<tr>
<td>16</td>
<td>OTHER SERVICES*</td>
<td>The full set of covered benefits is defined by the California EHB Benchmark plan.</td>
<td>NONE</td>
</tr>
</tbody>
</table>

* Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.
QUESTIONS?

patrick.chang@sfdph.org  (415) 554-2925