SFHSS Rules and Section 125 Cafeteria Plan

PY2027 Revisions Presentation

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Agenda

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- **San Francisco Health Service System Governing Rules**
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  - Key Requirements of the Section 125 Cafeteria Plan
  - Why the Section 125 Cafeteria Plan matters to employees and the City
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Annual Review and Approval Process

Annual review is a governance control: it creates a regular opportunity to align plan language, benefit limits, vendor references and operational practices with current requirements.

1 Annual Review

The Health Service System reviews the SFHSS Rules and 125 Cafeteria Plan on an annual basis to ensure ongoing regulatory compliance, accuracy, and protection for both employer and employees.

2 Full Health Service Board

Recommendations approved by the Governance Committee proceed to the full Board for review and approval.

3 Governance Committee

Recommended changes are presented for review, discussion and approval.

What is a Section 125 Cafeteria Plan?

- A Section 125 Cafeteria Plan is an employer-sponsored program governed by Section 125 of the Internal Revenue Code (IRC), 26 U.S.C. § 125, that allows eligible employees to pay for certain qualifying benefits and expenses using pre-tax dollars.
  - Why is it called a cafeteria plan? Similar to choosing items from a cafeteria menu, employees can select from the eligible benefit options their employer offers.

- Employees elect eligible benefits, and the cost of those benefits is deducted from their pay before applicable taxes are calculated.
  - Some examples include:
    - Medical, dental, and vision insurance premiums.
    - Health care Flexible Spending Accounts (FSAs).
    - Dependent care Flexible Spending Accounts (FSAs).

Key Requirements of the Section 125 Cafeteria Plan

- **Written Plan Document**: Employers must maintain a written plan document that describes the benefits offered, eligibility requirements, participation rules, and how the plan operates, in accordance with applicable IRS regulations (Prop. Regs. § 1.125-1(c)).

- **Employee Elections**: Employees generally must elect their benefits before the applicable plan year or coverage period begins. Once the plan year starts, elections are generally irrevocable unless the employee experiences a qualifying event and the requested change is permitted under the plan and applicable IRS regulations (26 CFR § 1.125-4).

- **Nondiscrimination Requirements**: The plan must satisfy applicable nondiscrimination rules to ensure that benefits and eligibility do not improperly favor highly compensated employees (HCEs) or key employees. (26 U.S.C. § 125).

- **Consistent Administration and Recordkeeping**: Employers must administer the plan according to its written terms, maintain appropriate records of employee elections and qualifying changes, and **apply plan rules consistently to support compliance** and preserve the intended tax advantages.

Why the Section 125 Cafeteria Plan Matters

For Employees

- Lower taxable wages for eligible elections
- Potentially lower federal income tax and payroll taxes
- More take-home pay from the same gross compensation
- Access to qualified health and dependent-care benefits through payroll

For the City/Employer

- Lower employer Social Security and Medicare tax on eligible salary reductions
- A more tax-efficient benefits package without necessarily increasing gross compensation
- Clear, consistent administration and stronger compliance controls

Employee Savings—2026*

Estimated employee tax savings: $1.01M-1.80M

Estimated employee tax savings using the 19.45%–34.75% range.

City/Employer Savings—2026*

Estimated employer payroll-tax savings: $396,703

Estimated employer Social Security and Medicare tax savings at 7.65%.

Up to $2.20 million* in estimated combined tax savings are associated with the reported pretax deductions. Maintaining Section 125 compliance helps protect the tax advantages employees receive through eligible pretax benefit elections while reducing potential employer payroll-tax exposure for the City.

*These are estimates based on year-to-date date and only include date for CCSF and Superior Court employees. SFUSD and SF City College payroll system data is not available.

Purpose of the SFHSS Rules

The San Francisco Health Service System (SFHSS) Rules establish a consistent and transparent framework for managing health benefits for eligible members and their dependents.

Adopted in accordance with the San Francisco City Charter, Administrative Code, and relevant state and federal laws, including IRS Section 125, the rules ensure fairness and accountability in the administration of health benefits. By clearly defining eligibility, enrollment, benefits, and appeals procedures, the SFHSS Rules uphold uniform standards that promote equitable access, regulatory compliance, and trust in the system's operations.






Recommended Revisions for Plan Year 2027

SFHSS Rules

- A,
- A.2.b.i,
- A.6.e,
- B.3, I.1.b.ii, and O.c-f,
- B.3.d,
- B.4,
- G.1-2,
- G.3.a,
- G.4 and P.1.d,
- L.2,
- T.9,
- J and Q,
- J.6,
- Appendix A

125 Cafeteria Plan

- B3.1 and B3.6,
- C3.1,
- D4.2.b,
- Appendix E

Proposed SFHSS Rules Change Highlights: More Time for Life's Important Moments

What Changed?

1. Newborn Children: Extended the Qualifying Life Event (QLE) enrollment deadline from 30 to 60 days. Coverage eligibility for a newborn continues to begin on the date of birth, and

2. Surviving Spouses/Registered Domestic Partners: Extended the QLE enrollment deadline from 30 to 60 days following the member's death, giving surviving family members additional time to complete enrollment.

Our Goal

Make SFHSS enrollment requirements more accessible, compassionate, and responsive to members' needs while maintaining consistent administration of the Rules.

Why We Made These Changes

- **Responding to Member Needs**: Extended enrollment deadlines to provide members with more time to navigate these two life events and complete required enrollment steps.
- **Reducing Administrative Burden**: Recognizes that welcoming a new child or experiencing the loss of a loved one can be overwhelming, making additional time to gather documentation and submit enrollment requests especially valuable.
- **Improving Access and Clarity**: Provides a clearer, more supportive enrollment process and reduces the risk of members missing enrollment deadlines during significant life transitions.

Proposed SFHSS Rules Change Highlights—Continued: Improving the Member Appeals & Grievance Experience

What Changed?

The Rules were revised to provide definitions and guidance on how members can navigate eligibility appeals, health plan appeals, and grievances.

Our Goal

To make the SFHSS Rules a more accessible and effective resource for members by clearly explaining their options, identifying where to direct appeals, and outlining the steps involved in the process. Members should be better equipped to understand the process, know what to expect, and determine the appropriate next steps.

Why We Made These Changes

These revisions prioritize member education, transparency, and support by making the procedures easier to understand and navigate. Ultimately, the changes are intended to reduce confusion, set clear expectations, and improve the member experience when addressing concerns or disputing a benefits decision.

Recommendation for HSB Action

It is recommended that the Health Service Board approve the proposed language revisions and rule changes within the San Francisco Health Service System Rules and Cafeteria Plan, for Plan Year 2027.

Appendix: SFHSS Rules and Section 125 Cafeteria Plan PY2027 Revisions Summary

October 26, 2026 - Summary of Proposed Policy Changes
Health Service System Rules Plan Year 2027

The section and page numbers in this document refer to the SFHSS Rules PY2027 DRAFT rules located behind this summary. Throughout the document changes are made to dates to reflect that the Rules be updated for the 2027 Plan Year. In addition, minor modifications to the document have been made to improve the documents readability, including removal of duplicative information, updating of terms, and adjustment of section numbering. All substantive policy changes are listed below.

Section	Policy Clarification / Change	Rationale
Sec A	Clarification added to the definition of hire date and appointment date for the purpose of determining the initial enrollment period for Active Members.	Clarifying the definitions of hire date and appointment date provides greater consistency and transparency in determining an Active Member's initial enrollment period. This helps ensure that members and staff have a shared understanding of when the enrollment period begins and supports accurate, consistent application of the 30-day enrollment requirement.
Sec A.2.b.i	Updated eligibility for former Board of Supervisors for health benefits.	SFHSS Rules aligned with San Francisco City Charter Section A8.425.
Sec A.6.e	This rule update is an alignment of SFHSS Rules with California Senate Bill No. 11.	This rule clarifies SFHSS benefit eligibility for San Francisco Superior Court Judges in alignment with California Senate Bill No. 11 (2009–2010) and applicable state law governing supplemental benefits for judges.
Sec B.3, I.1.b.ii, and O.c-f	Enrolling a dependent as a new born, under a qualifying life event (QLE) has been extended from 30 to 60 days. Eligibility for the new born child will continue to start as of the date of the child's birth. 29 CFR § 2590.701-6(b)(3)(iii)(B).	Extending the enrollment period from 30 to 60 days provides members with additional time to report a qualifying life event and complete the required enrollment steps. This change supports the member experience, reduces the risk of missed enrollment opportunities, and allows members more time to navigate the enrollment process.

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Section	Policy Clarification / Change	Rationale
Sec B.3.d	Removed the requirement for Adult Disabled Children to be enrolled in Medicare.	Removing the requirement for Adult Disabled Children to enroll in Medicare eliminates an unnecessary enrollment requirement that does not change how their coverage is coordinated. Medicare would remain the secondary payer, and enrollment in Medicare would not automatically transition the dependent to a Medicare Advantage plan. This clarification helps prevent confusion and establishes a more accurate understanding of the relationship between Medicare eligibility and SFHSS health plan coverage.
Sec B.4	Adding a surviving spouse/registered domestic partner after the death of the member has been extended from 30 to 60 days. Eligibility for the surviving spouse/registered domestic partner will be prospective, but can be reviewed on a case by case basis, if retroactive enrollment is requested.	Extending the enrollment period from 30 to 60 days following the death of a member provides surviving spouses and registered domestic partners with additional time to understand their options, gather required documentation, and complete the enrollment process during a difficult and often stressful time.
Sec. G.1 and 2	Added citation to Sec. I.1.3 for HIPAA Special Enrollment rights.	Adding a citation to Section I.1.3 provides a direct reference to the applicable HIPAA special enrollment requirements. This improves transparency, strengthens the connection between SFHSS Rules and governing federal requirements, and helps members and staff locate the legal basis for special enrollment rights.

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Section	Policy Clarification / Change	Rationale
Sec G.3.a	Clarifying language added to Loss of Other Coverage to include that the loss of other coverage is involuntary.	Clarifying that the loss of other coverage must be involuntary helps members and staff better understand when a loss of coverage qualifies as qualifying life event. This supports consistent eligibility determinations, reduces ambiguity, and helps members distinguish qualifying events from situations in which other coverage is voluntarily discontinued.
Sec G.4 and P.1.d	Clarification added providing the time period of when retiree health benefits will be terminated upon member's request to terminate health coverage with SFHSS.	Specifying the time period for terminating retiree health benefits when a member requests to end SFHSS health coverage provides greater transparency regarding when coverage will end. This helps members understand the timing and potential implications of their request, supports informed decision-making, and enables staff to apply termination procedures consistently.
Sec L.2	The rule establishes the requirement to terminate SFHSS-sponsored coverage for Retiree Members/dependents who are incarcerated or deceased when their Medicare coverage is terminated by the Social Security Administration, consistent with applicable federal regulations. For other instances of noncompliance with required Medicare enrollment, the Retiree Member will be automatically transitioned to the Blue Shield of California-20 Plan, which provides coverage at a higher out-of-pocket cost to the Retiree Member.	This rule aligns SFHSS policy with applicable Centers for Medicare & Medicaid Services (CMS) requirements and establishes consistent procedures for addressing Medicare enrollment noncompliance. It clarifies the applicable coverage outcome based on the circumstances, supporting regulatory compliance while allowing Retiree Members who fail to maintain required Medicare enrollment for reasons other than incarceration or death to retain SFHSS-sponsored coverage through the Blue Shield of California-20 Plan.

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Section	Policy Clarification / Change	Rationale
Sec T.9	The update clarifies that continued eligibility for SFHSS retiree health benefits is contingent upon the Retiree Member maintaining eligibility for retirement benefits through their applicable retirement system.	The rules aligns SFHSS health benefit eligibility with the Retiree Member's eligibility to receive and maintain retirement benefits. Alignment with San Francisco Charter Section A8.603-10.
Sec J and Q	Clarifying language was added that retiree health benefits are administered in accordance with San Francisco City Charter Section A8.428.	This section is added to clarify that SFHSS administers retiree health benefit eligibility, employer contributions, and enrollment timelines in accordance with San Francisco City Charter Section A8.428, including the distinctions established under Proposition B for employees hired on or after January 10, 2009.
Sec J.6	Added clarifying language on benefit eligibility and cost for members rehired under Prop F.	This rule clarifies the health benefit eligibility and premium treatment of retirees rehired under San Francisco City Charter Section A8.511(c), ensuring their temporary employment does not alter their retiree health benefits or establish eligibility for active-employee health benefits.
Sec V	Clarification added to the Appeals and Grievance process. Specifically, appeals and grievances are defined, and first and second level appeals are distinguished.	Defining appeals and grievances and distinguishing between first-level and second-level appeals clarifies the available processes for members who wish to challenge a determination or express dissatisfaction with services. This helps members better understand their options, the appropriate process for raising a concern, and the applicable review steps. The clarification also promotes consistent administration and reinforces transparency regarding how member concerns and disputes are handled.
Appendix A Update		Appendix A Calendars have been updated to reflect the employer pay periods for calendar year 2027.

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Section	Policy Change	Rationale
Sections B3.1 and B3.6	Updated to reflect increase the Health Care FSA limits to $3,400 per year, up from $3,300 in 2026, and increase the carryover amounts to $680 per year, up from $660.	On December 23, 2025, the Internal Revenue Service (IRS) released updated flexible spending account (FSA) limits for 2026. Int. Revenue Serv., U.S. Dep't of the Treasury, Publ'n No. 15-B, Employer's Tax Guide to Fringe Benefits: For use in 2026. SFHSS is one year behind the IRS published rates, as the rates are issued after the annual Open Enrollment.
Section C3.1	Updated to reflect the increased Dependent Care FSA maximum and minimum contribution limits established by SFHSS. The limits are structured using a two-tiered approach based on the IRS definition of Highly Compensated Employees (HCEs).	Public Law No. 119-21 (H.R. 1, 119th Congress) establishes the maximum Dependent Care FSA contribution permitted under federal law. Within that federal limit, SFHSS establishes the contribution amounts permitted for Highly Compensated Employees (HCEs) and non-HCEs to ensure the plan complies with IRS nondiscrimination requirements.
Section D4.2.b	Updated 2027 Flexible Credits dollar values for CCSF and Superior Court employees.	2027 Benefit Program Update due to M.O.U. compliance.
Appendix E	• Updated Vendor Names and Policy Numbers • Updated available Voluntary benefits made. • Updated the regulatory body for final appeals.	2027 Benefit Plan Update per approval by the San Francisco Health Service Board in 2026.