SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

March 12, 2020

TO: Karen Breslin, President, and Members of the Health Service Board

FROM: Abbie Yant, RN, MA Executive Director SFHSS

RE: March 2020 Board Report

Vendor Black Out Period – Reminder
The HSB approved the vendor Black Out period commenced February 13, 2020. As a reminder, this blackout period is still in effect. Medical, Dental, and Vision vendor renewal meetings are now underway. The current version of the Rates and Benefits Calendar is in your meeting packet.

HSB 2020 Election
The Health Service Board 2020 Election process has declared Claire Zvanski as the newest member of the Health Service Board. By February 14, 2020, only one member submitted the nomination form with the required number of signatures to the Health Service Board Secretary– leaving only one candidate for the one Health Service Board seat up for election. Under Administrative Code Section 16.553, if there are no competing candidates for an open seat, then the Department of Elections is no longer required to hold an election, and the eligible candidate will be declared to be a member of the Health Service Board. Thus, the remaining candidate is now eligible to assume the open seat as of May 15, 2020. The candidate will be sworn into their office after May 15 and before the Health Service Board's June 2020 meeting.

At this point, SFHSS Management and the Board Secretary would like to congratulate the candidate and incoming Health Service Board member, Ms. Claire Zvanski.

COVID 19 Update
As you are aware, on Tuesday, February 25, Mayor Breed declared a local emergency in the City and County of San Francisco to prepare for COVID-19 (Novel Coronavirus) spread in our City. The declaration mobilizes city resources, activates Disaster Services Workers, accelerates emergency planning, and allows for future reimbursement by the state and local governments. City workers are on notice that they may be called to action as a Disaster Service Worker to support the response effort for this situation. For more information about Disaster Service Workers, visit https://sfdhr.org/disaster-service-workers.

SFHSS is monitoring the situation and updating our website with information and links to trusted resources during this time. Leadership has developed contingency plans to: maintain services for our members, continue to process incoming invoices and outgoing payments, and proceed with the Rates & Benefits process should we experience a reduction in staffing.

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Infertility Services Update
SFHSS continues to work with Blue Shield of California to ensure that services provided for our members trying to have families who may be accessing Infertility Benefits are no longer experiencing barriers. BSC has developed a workflow that includes consultation with a navigator with expertise in this program. The pharmacy matter is complicated, and BSC is still seeking solutions. At this writing, BSC plans to report out on this matter at the April HSB meeting. SFHSS Communications team is in consultation with BSC and other carriers on a communications plan that will assist our members in understanding their access to these services.

Sutter Antitrust Case Update: per Pacific Business Group on Health
The Superior Court of San Francisco County delayed preliminary approval of the proposed UFCW/Attorney General settlement with Sutter Health regarding antitrust and claims pricing over the last decade. As a reminder, the settlement impacts public entities and self-funded employers headquartered in California. The next hearing date is April 6, and the plaintiff's attorneys and AG's office have been asked to provide briefs by March 18 on the following:

- Impact of potential changes in federal health policy given the proposed 10-year duration of the injunctive relief
- Explanation of the attorneys' fees
- Steps were taken to ensure that diversity is considered in selecting the Monitor that will oversee adherence to the settlement terms

The judge also requested a plain-language summary of how the settlement will work and clarification on terms and processes in the injunctive relief and class application.

Sutter previously filed a motion to seal pricing information, specifically the multiplier used to limit out-of-network charges as well as the cap on the annual increase in billed charges. Although the Carpenters' Union filed a motion seeking to ensure this information is disclosed, the judge ruled in favor of Sutter's motion to redact it. However, Class members may access the information upon completion of a non-disclosure agreement.

EAP/Mental Health
San Francisco Health Service System (SFHSS) is developing a new general fund budget proposal that expands the Employee Assistance Program (EAP) in response to the rising demand for mental health services. The recommendation for program expansion is based on gathered input from member engagement feedback, trends in service utilization, and clinical research.

Attachments:
ESA Slide
Legislative Report
Black Out Period Memo
Well Being Report

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SFHSS DIVISION REPORTS – March 2020

PERSONNEL
Welcome Jessica Shih, Communication Director started on March 2, 2020.

Open Positions:
- PCS 0923 Assistant Well-Being Manager: Interviews scheduled
- TEX 1210 Benefits Analyst recruitment underway
- PCS 1209 Benefits Technician – recruitment underway

Future Vacancies:
- CFO 0953 – Recruitment underway

Employee Engagement Activity
Career Development Workshop Part 1 completed at January 30 SFHSS All Staff Meeting.

OPERATIONS –

In February, call volume was consistent for this time of the year. Average Speed of Answer dropped from 19 seconds to 14, and the Abandonment Rate (dropped calls) was less than 1 %. These metrics are considerably better than industry standards. The SFHSS leadership believes that these numbers will improve once the open positions in Member Services are filled.

LEAN Process Improvement
As a result of process improvement work, Delinquency Termination Notifications have dropped by nearly half over the same time last year (176 in February 2019 to 93 this February). Delinquency notification letters were rewritten with improved messaging that was developed in our Behavioral Insights sessions. The improved letters will be sent with March delinquencies, and we expect an improvement with further decreasing terminations.

SFUSD
SFHSS is also consulting with SFUSD on the implementation of their new Human Resources software (from PeopleSoft to SAP.) Operations staff have attended 9 hours of workshops with the implementation partner to help with questions regarding interfaces, data elements, and design. Discussions are ongoing regarding SFHSS adding SFUSD employees to our dental plans.

Enterprise Systems & Analytics (ESA) – see project dashboard
New Payment Portal
Members can now go online to the City's secure payment portal to pay for their health insurance. The portal went live on February 12, and SFHSS is the first City department to partner with the City's payment processor to deliver this functionality. This milestone marks the continued effort to provide self-service functionality to our members for convenience.

Anthony Gan was instrumental in defining the requirements, conducting testing, working directly with the vendor, and training our staff on the system.

Voice Over Internet Protocol (VOIP)
The SFHSS new telephone system goes live on March 13. The VOIP project is the culmination of a multi-year effort to replace our phone system, which doesn't have enough lines, and during peak call volumes could overload. The change to Voice Over Internet Protocol (VOIP) positions SFHSS to move forward with additional system integrations, which will help with the more intelligent routing of calls to help service our members. SFHSS phone numbers are changing. Call forwarding for SFHSS main phone numbers will be in effect until the end of the year as we educate our members about the new phone numbers.

Benefit Administration Software
The SFHSS Benefit Administration software will be offline March 27 at noon and be operational March 30 for a system upgrade. The staff has access to the testing environment beginning on March 9 to ensure a smooth transition to the upgraded software. Procedures are in place for planned downtime.

COMMUNICATIONS

- Designed and Conducted the Ten County Survey for 2020 with medical premiums, employer contribution, and plan design
- Submitted data for the CCSF County-wide Cost Allocation Plan for use by the Controller's Office
- Forms 1099 review for 2019
- Submitted SFHSS Proposed FY 2020-21 and FY 2021-22 General Fund Administration Budget to the Mayor's Office one day before the Charter mandated deadline
- Completed complying of document requests for the FY 2018-19 Post Audit from the Controller's Office and the Office of Contract Administration

FINANCE DEPARTMENT

- Conducted the Ten County Survey for 2020 with medical premiums, employer contribution, and plan design
- Submitted data for the CCSF County-wide Cost Allocation Plan for use by the Controller's Office
- Forms 1099 review for 2019
- Submitted SFHSS Proposed FY 2020-21 and FY 2021-22 General Fund Administration Budget to the Mayor's Office one day before the Charter mandated deadline
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Contracts

- Fully executed agreement with UnitedHealthcare (ASO-PPO)
- Finalized UnitedHealthcare prescription drug list (PDL) biannual assessment.
- Fully executed a letter agreement with Kaiser for the health premium payment process.
- Fully executed agreement with the YMCA of San Francisco for 2020 Change, Intervention, and Diabetes Prevention Program (DPP).
- Selected Design Media for 2020 Well-Being nutrition campaign development and EAP resource guide design services.
- Finalized performance guarantees through PY2021 with The Hartford.

Well-Being

EAP

· All counselors started the Police Community Academy on 2/27 (10-week program)
· Jeannette Longtin received training in CPI (De-escalation training)

Well-Being@Work

· 887 members screened at 18 screening events across the City
· three healthy weight programs starting with 46 individuals registered

Wellness Center

· Provided a Wear Red for heart health event yielding 79 participants
· Increase participation by 60.5% from the same time last year

Management Report

March 12, 2020

Project	Status	Key Accomplishments
Cybersecurity / Disaster Preparedness		• Incident Action planning underway to prepare for possible impacts of COVID-19
eBenefits		• Met with SFUSD regarding timing of summer hiring and offering online enrollment for new hires • Meeting with Systems Division to procure environment to complete retrofit of New Hire / Life Events due to PeopleSoft Upgrade. If an environment cannot be made available, our schedule is impacted
VOIP telephony upgrade		• Network cutover occurred 3/5 • Training scheduled for 3/5 and 3/12 for using the call center functions (Member Services) • Training scheduled for 3/9, 3/16 and 3/23 on using the new phones (standard user) • System to be activated March 13
Payment Gateway: Member facing payments		• Payment portal live as of February 13 • Post deployment support phase
Enterprise Content Management System (ECM) Business Insights / scanner licenses		• SQL Server requisitioned • Test environment prepared
1095 Regulatory filing		• 1095 filing with the IRS of original submission is complete • Reviewing errors for correction (routine occurrence)

 On Schedule, Adequate Resources, Within Budget, Risks in Control

 Potential issues with schedule /budget can be saved with corrective actions

 Serious issues. Project most likely delayed or significant budget overrun

Well-Being@Work: Activities at Department Location

Total Onsite Activities - YTD

(Provided by KP and SFHSS Well-Being Team)

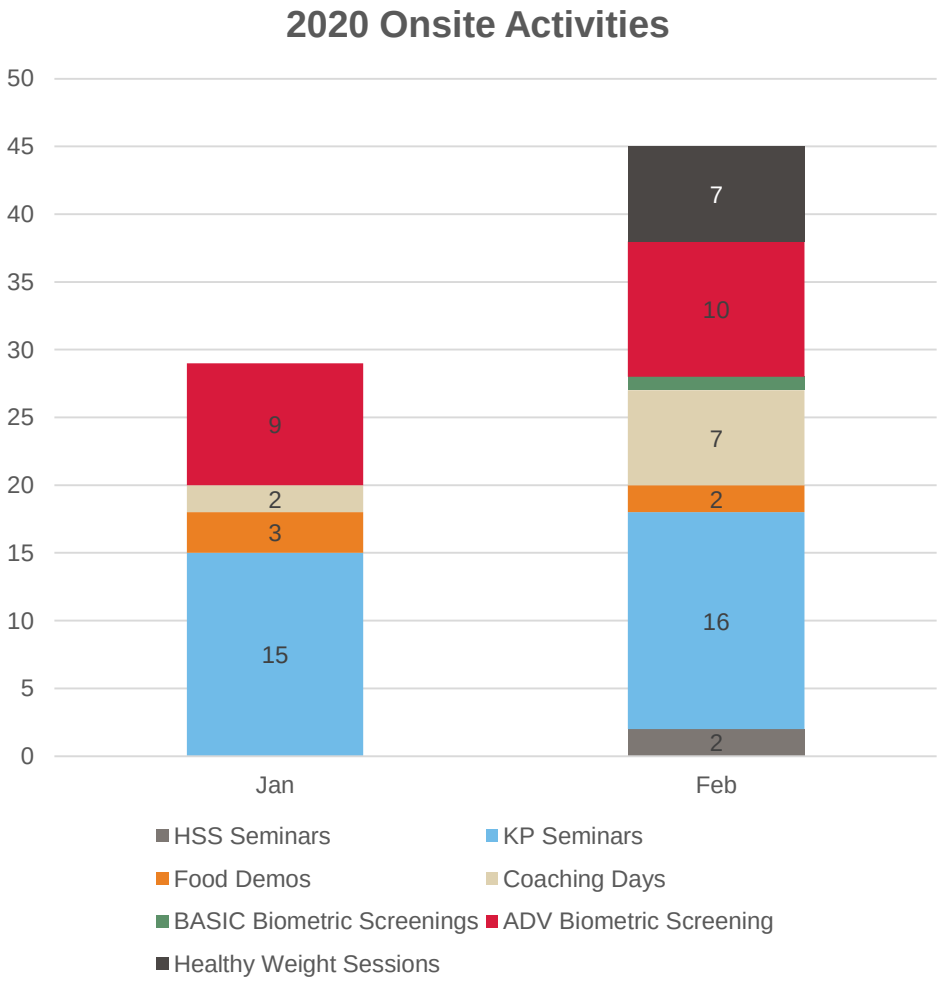
- 67

February 2020

- 30 activities offered at 17 departments locations

February Highlights

- 11 Screenings offered through Live Feel Be Better campaign
- Office of Resilience and Compliance (ADM-ORCP) hosted an event at City Hall to kick-off the New Year by promoting ways to be active with nearby activities and onsite resources
  - 82 attended



Campaign: Live, Feel Be Better 2020:

Aimed to Empower Members to take action with two programs to initiate healthy behaviors in 2020:

- **18 Advanced Health Screenings:** *know your numbers* and learn your health risk factors
  - ✓ **887 Members Served**
- **3 Healthy Weight Programs:** *get support* with a 7-week program to support group members with guided discussions that educate participants on nutrition, exercise, stress, and motivation
  - ✓ **46 Members Registered**

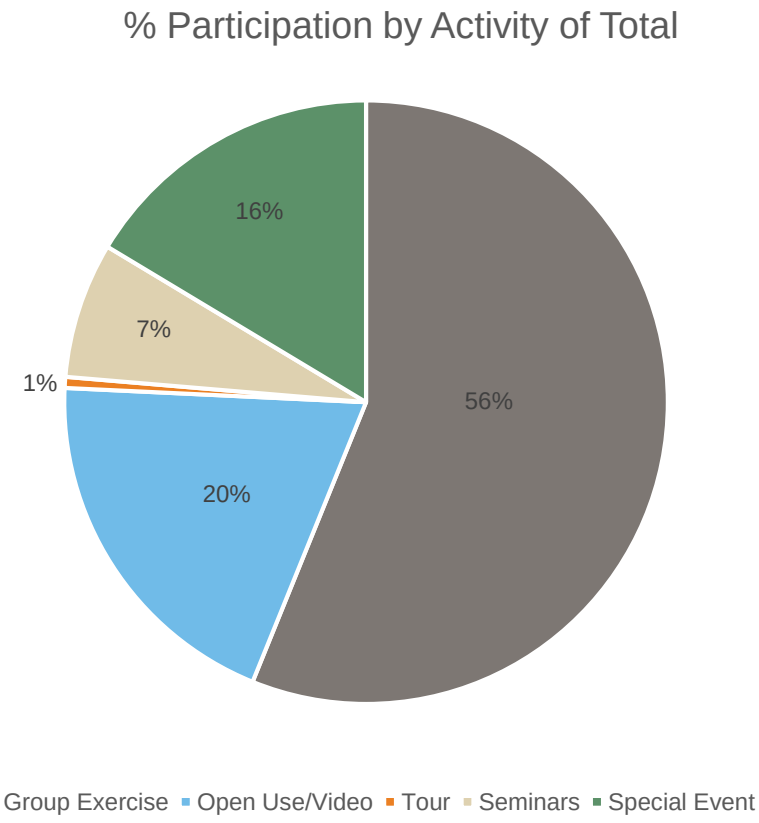
Catherine Dodd Wellness Center

Total Participation

- YTD – 1,394 (25.47% increase from 2019)
- February – 936 (60.5% increase from February 2019)
  - Special Events and Open Use have contributed to a large increase in total participate from February 2019.

Group Exercise

- Represents 56% of all activities
- Zumba (Noon Wednesdays) – highest participating class
  - **31 participants on average**



Catherine Dodd Wellness Center: Event Highlights

Ergonomics Training: 2/6

- **11 engaged**

Wear Red Day for Health: 2/7

- Life's Simple Seven (My Life Check) presentation
- Variety of activity tables to bring awareness to heart health
- **79 engaged**

Health Screening: 2/14

- Included: glucose, blood pressure, body mass index and body fat percentage.
- **59 engaged (84% show rate)**

Healthy Weight Program: Launched 2/20

- 2 sessions offered in February
  - **16.5 average participants per class**

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MEMORANDUM

DATE: February 13, 2020

TO: Karen Breslin, President, and Members of the Health Service Board

FROM: Abbie Yant
SFHSS Executive Director

RE: Black-Out Notice for 2021 Rates and Benefits

This memorandum shall notify the Health Service Board ("Board") of the Blackout Period in connection with the San Francisco Health Service System ("SFHSS") Rates and Benefits process for the 2021 plan year.

Pursuant to the Board's Service Provider Selection Policy, the Board must be notified of a Blackout Period prior to the release of any solicitation for the selection of a primary service provider which includes the annual SFHSS Rates and Benefits process.

During the Blackout Period, the Board is prohibited from any communications with a potential SFHSS service provider on matters relating to SFHSS contracting except communications on SFHSS matters during Board or Board Committee Meetings.

Communications include face-to-face conversations, telephone conversations, email, text messages, letters, faxes or any other social media, written or electronic communications.

Any communications with service providers for reasons unrelated to SFHSS during the Blackout Period must be immediately disclosed in writing to the Director and the Board.

The Blackout Period shall commence on February 13, 2020 and is expected to end on or before July 2020 Board of Supervisors final approval.

LEGISLATIVE UPDATE MARCH 12, 2020

	Subject	Legislation Title	Activity	Comment
SURPRISE MEDICAL BILLING				
Federal	Surprise Medical Billing	HR 5800 Ban Surprise Billing Act	Introduced February 2, 2020 and referred to the House Committee on Energy and Commerce, and in addition to the House Committees on Education and Labor, and Ways and Means, and Oversight and Reform	The bill would require a group health plan to provide services without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating insurance providers and participating emergency facilities with respect to such plan or coverage.
MEDICARE				
Federal	Medicare	S 3237 WELL Seniors Act of 2020	Introduced January 28, 2020 and referred to the House Committee on Finance.	The bill would improve the annual wellness visit under the Medicare program.
Federal	Medicare	S 3238 Preventive Home Visit Act	Introduced January 28, 2020 and referred to the House Committee on Finance.	The bill would provide coverage of preventive home visits under Medicare by establishing a bundled payment amount for a preventive home visit, including any referrals made in connection with the visit.
RULE MAKING				
Federal	Department of Health and Human Services, Centers for CMS Proposed Rule Change	Federal pre-rulemaking process for the selection of quality and efficiency measures for use by HHS public call	In January 2020, HSS initiated new rule making concerning quality and efficiency measures. Comments are due in May 2020.	This bill would fill critical gaps in measurement that align with and support the "Meaningful Measures Framework". The purpose is to improve outcomes for patients, their families and providers while also reducing burden and moving payment toward value through focusing everyone's efforts on the same quality areas. The Meaningful Measures Initiative also helps to identify and close important gap areas of measures, align measures across the continuum of care and across payers, and to spur innovation in new types of measures such as patient reported measures and electronic measures.

LEGISLATIVE UPDATE MARCH 12, 2020

	Subject	Legislation Title	Activity	Comment
Federal	Department of Health and Human Services, Centers for CMS Proposed Rule Change	Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements.	Proposed rule was issued on July 18, 2019 and comments are due by September 9, 2019. Final rule issued November 8, 2019 with a comment close date of December 30, 2019. This final rule with comment period is effective January 1, 2020.	This rule would update the prospective payment system (HH PPS) payment rates and wage index for CY 2020; implement the Patient-Driven Groupings Model (PDGM), a revised case-mix adjustment methodology, for home health services beginning on or after January 1, 2020, implement a change in the unit of payment from 60-day episodes of care to 30- day periods of care, and proposes a 30-day payment amount for CY 2020. Additionally, this proposed rule modifies the payment regulations pertaining to the content of the home health plan of care; allow physical therapy assistants to furnish maintenance therapy; and change the split percentage payment approach under the HH PPS. This may impact the development of the Kaiser and UHC 2021 Medicare plan rates.
Federal	Internal Revenue Service, Employee Benefits Security Administration, Health and Human Services Department Proposed Rule	Proposed Rule to require groups health plans to disclose cost sharing information	An Executive Order by President Trump was issued June 24, 2019 and was published in the Federal Register on June 27, 2019. The rule was filed on November 27, 2019 with a January 14, 2020 deadline for comments. The rule is still in the proposed rule stage. All components of the rule would be applicable for plan years (or in the individual market policy years) beginning on or after 1 year after the finalization of the rule, except for the MLR provision, which would be applicable beginning with the 2020 MLR reporting year	The rule requires group health plans to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee (or his or her authorized representative), including an estimate of such individual's cost-sharing liability for covered items or services furnished by a provider. Plans and issuers are to make such information available on an internet website and, if requested, through non-internet means, thereby allowing a participant, beneficiary, or enrollee (or his or her authorized representative) to obtain an estimate and understanding of the individual's out-of-pocket expenses and effectively shop for items and services. The rules also require plans and issuers to disclose in- network provider negotiated rates, and historical out-of-network allowed amounts through files posted on an internet website. The HHS proposes amendments to its medical loss ratio program rules to allow issuers offering group health insurance coverage to receive credit in their medical loss ratio calculations for savings they share with enrollees that result from the enrollee's shopping for, and receiving care from, lower-cost, higher-value providers.

LEGISLATIVE UPDATE MARCH 12, 2020

	Subject	Legislation Title	Activity	Comment
Federal	Department of Health and Human Services, Office of Inspector	Medicare and State Healthcare Programs, Fraud and Abuse, Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements	Proposed rule was issued on October 17, 2019 and comments are due on December 31, 2019. The rule is still in the proposed rule stage.	The bill would remove potential barriers caused by four key healthcare laws and associated regulations that impact more effective coordination and management of patient care and delivery of value-based care that improves quality or care, health outcomes, and efficiency. The four key healthcare laws and associated regulations: (i) The physician self-referral law, (ii) the Federal anti-kickback statute, (iii) the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[9] and (iv) rules under 42 CFR part 2 related to substance use disorder treatment.
COST OF DRUGS				
Federal	Orphan Drugs	S 3271 Fairness in Orphan Drug Exclusivity Act	Introduced February 11, 2020 and referred to the Senate Committee on Health, Educations, Labor and Pensions	The bill would limit amend the Federal Food, Drug, and Cosmetic Act with respect to limitations on exclusive approval or licensure of orphan drugs.
Federal	Cost of Prescription Drugs	S. 3166 Prescription Drug Affordability and Access Act	Introduced January 8, 2020, Read twice and referred to the Senate Committee on Health, Education, Labor, and Pensions. No change since January 8, 2020	The bill would lower the cost of drugs for all Americans.
Federal	Drug Pricing, Out-of Pocket Maximums, Transparency	S. 2543 Prescription Drug Pricing Reduction Act of 2019	Introduced September 25, 2019 and referred to the Senate Committee on Finance. Senate Report 116-120 was issued on September 25, 2019. No action since September 25, 2019.	The bill may impact the UHC MAPD rates. It changes the Medicare Part D program by the removal of the coverage gap, reducing the true out-of-pocket expense, improving incentives to increase negotiation between prescription drug plans and manufacturers, protecting the program from manufacturer drug price increases, and increasing transparency into pharmacy benefit manager (PBM) practices and manufacturer drug pricing decisions.

LEGISLATIVE UPDATE MARCH 12, 2020

	Subject	Legislation Title	Activity	Comment
Federal	Cost of drugs	H. R. 3 Elijah E. Cummings Lower Drug Costs Now Act	Introduced September 19, 2019. Amended by the House Committee on Energy and December 12, 2019 and referred to the House Committee on the House Committee on Energy and Commerce, House Committee on Ways and Means and House Committee on Education and Labor. Passed by House on December 12, 2019. Received in Senate December 16, 2019. No action since December 16, 2019.	The bill would require CMS to negotiate prices for certain drugs (current law prohibits the CMS from doing so). Specifically, the CMS must negotiate maximum prices for (1) insulin products; and (2) at least 25 single source, brand-name drugs that do not have generic competition and that are among the 125 drugs that account for the greatest national spending or the 125 drugs that account for the greatest spending under the Medicare prescription drug benefit.. The bill also makes a series of additional changes to Medicare prescription drug coverage and pricing. Among other things, the bill (1) requires drug manufacturers to issue rebates to the CMS for covered drugs that cost $100 or more and for which the average manufacturer price increases faster than inflation; and (2) reduces the annual out-of- pocket spending threshold, and eliminates beneficiary cost-sharing above this threshold, under the Medicare prescription drug benefit.
Federal	Cost of Insulin	H. R. 5364 End Price Gouging for Insulin Act	Introduced on December 9, 2019, referred to the House Committee on Energy and Commerce and the House Committees on Ways and Means, Armed Services, Veterans' Affairs, Oversight and Reform and Natural Resources , for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. Referred to House Subcommittee for Indigenous Peoples by the House Committee on Natural Resources on December 18, 2019 and to the to the House Subcommittee on Health by the Committee on Veterans' Affairs on January 14, 2020.	The bill would require the Secretary of Health and Human Services to establish an annual reference price for insulin products for purposes of Federal health programs.

LEGISLATIVE UPDATE MARCH 12, 2020

	Subject	Legislation Title	Activity	Comment
Federal		H. R. 4457 Chronic Condition Copay Elimination Act	Introduced on September 24, 2019 and referred to the House Committee on Energy and Commerce, House Committees on Education and Labor, House Committee for Ways and Means. Referred to the Subcommittee on Health by the Committee on Ways and Means on September 24, 2019 and referred to the House Subcommittee on Health by the Committee on Energy and Commerce on September 25, 2019.	The bill may impact SFHSS since it will require group health plans and health insurance issuers offering group or individual health insurance coverage to provide coverage for additional preventive care for individuals with chronic conditions without the imposition of cost sharing requirement, and for other purposes. Chronic Conditions are defined as Heart disease, including congestive heart failure and coronary artery disease, diabetes, osteoporosis and osteopenia, hypertension, asthma, liver disease, bleeding disorders, and depression. The criteria is that the item or service is low- cost, there is medical evidence supporting high- cost efficiency, or a large expected impact, of the item or service in preventing exacerbation of the chronic condition or the development of a secondary condition, there is a strong likelihood, documented by clinical evidence, that the item or service will prevent the exacerbation of the chronic condition or the development of a secondary condition that requires significantly higher-cost treatments.
State	Pharmacy Benefit Management Reporting to the California Department of Managed Health Care (DMHC)	Required by AB 315 passed in 2018	The task force met July 31, 2019, September 12, 2019, October 14, 2019 and December 4, 2019. The DMHC's report to the Legislature based on Task Force recommendations is due February 1, 2020. The report is not currently available.	The result of the work of the Task Force will increase the transparency of how pharmacy benefit managers operate and determine if PBMs are serving the best interests of the patients, and not just increase the PBM's bottom line.
BENEFIT DESIGN				
Federal	Access to Primary and Behavioral Healthcare	H. R. 5575 Primary and Behavioral Health Care Access Act of 2020	Introduced January 10, 2020. Referred to the House Committee on Energy and Commerce, and in addition to the House Committees on Education and Labor, and Ways and Means. No change since January 16, 2020,	A bill would require group health plans and health insurance issuers offering group or individual health insurance coverage to provide for 3 primary care visits and 3 behavioral health care visits without application of any cost-sharing requirement.
Federal	Breast Cancer Diagnosis	S 3216 Access to Breast Cancer Diagnosis	Introduced January 16, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions, No change since January 16, 2020.	A bill would prohibit group health plans and health insurance issuers offering group or individual health insurance coverage from imposing cost-sharing requirements or treatment limitations with respect to diagnostic examinations for breast cancer that are less favorable than such requirements with respect to screening examinations for breast cancer.

LEGISLATIVE UPDATE MARCH 12, 2020

	Subject	Legislation Title	Activity	Comment
Federal	Protection for pre- existing conditions	H. R. 5479 To protect Americans with pre-existing conditions	Introduced December 18, 2019 and referred to the House Committee on Energy and Commerce No action since December 18, 2019.	The bill states that "No American shall be denied health insurance due to pre-existing conditions".
State	Health care coverage: treatment for infertility.	AB 2781 An act to repeal and add Section 1374.55 of the Health and Safety Code, and to repeal and add Section 10119.6 of the Insurance Code, relating to health care coverage.	Introduced February 21, 2020	This bill would require every health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2021, to provide coverage for the treatment of infertility. The definition of infertility would be revised, and would remove the exclusion of in vitro fertilization from coverage.
TRANSPARENCY				
Federal	Transparency	H. R. 5121 To amend title XXVII of the Public Health Service Act and chapter 89 of Title 5, United States Code, to require health insurance issuers to maintain a price comparison tool, and for other purposes.	Introduced on November 15, 2019, referred to the House Committee and Commerce and the House Committee on Oversight and Reform for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. No action since November 15, 2019.	The text of the bill is not available; however, it is expected that this will impact the SFHSS Blue Shield and UHC PPO plans.
Federal	Improving Provider Directories Act	H. R. 4575, a bill to amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require group health plans and health insurance issuers offering group or individual health insurance coverage to establish a process to address inaccurate information listed in publicly accessible provider directories of such plans and issuers, and for other purposes.	Introduce in House September 27, 2019, and referred to the House Energy and Commerce, House Education and Labor, and House Ways and Means Committee. Referred to the House Subcommittee on Health by the House Committee on Ways and Means on September 30, 2019 and referred to the Subcommittee on Health by the Committee on Energy and Commerce on September 30, 2019.	The bill will require plans to establish a process to address inaccurate information listed in any publicly accessible provider directory of such plan or issuer. The process shall include prominently displaying on each publicly accessible provider directory of such plan or issuer contact information, such as an email address, phone number, or website address, that will allow an individual to notify such plan or issuer of any inaccurate information listed with respect to a provider in such directory; investigate whether such information is inaccurate; and in the case that such plan or issuer determines that such information is inaccurate, correct and update such information in such directory; and submit to the State insurance commissioners of the States in which such plan or coverage, as applicable, is offered, and makes publicly available, an annual report on the number of notifications received during the year involved and the corrective actions taken with respect to such notifications.

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	Subject	Legislation Title	Activity	Comment
AFFORDABLE CARE ACT				
United States Department of Health and Human Services (HHS) Office for Civil Rights	Nondiscrimination in Health and Health Education Programs or Activities	On June 14, 2019 HHS proposed "substantial revisions" to regulations implementing ACA Section 1557. The proposal cannot change Sections 1557's protection in the law enacted by Congress but it would significantly narrow the scope of the existing HHS implementing regulations.	In May 2019, the Office for Civil Rights issued a new proposed rule and the comment August 13, 2019. The Trump administration asked the court to postpone a ruling until after the rulemaking process was completed. The government argued that the proposed rule, if finalized, would moot the litigation. The hearing was held September 2019. The judge issued a final judgment on October 15, 2019 and judge stated that the federal government did not cite a compelling governmental interest in the rule's protections based on gender identity and termination of pregnancy. The judge suggested that the government could instead help individuals find and pay health care providers that offer gender transition and abortion-related procedures. The Supreme Court is considering the scope of Title IX (the basis of 1557's sex nondiscrimination provision) this term. A decision is expected by the end of term (roughly June 2020).	The regulations would: a) eliminate the general prohibition on discrimination based on gender identity, as well as specific health insurance coverage protections for transgender individuals, b) adopt blanket abortion and religious freedom exemptions for health care providers, c) eliminate the provision preventing health insurers from varying benefits in ways that discriminate against certain groups, such as people with HIV or LGBTQ people d) weaken protections that provide access to interpretation and translation services for individuals with limited English proficiency, d) eliminate provision affirming the right of private individuals to challenge alleged violation of Section 1557 in court, obtain money damages, as well as requirements for covered entities to provide non- discrimination notices and grievance procedures.

LEGISLATIVE UPDATE MARCH 12, 2020

	Subject	Legislation Title	Activity	Comment
Court Case – US Court of Appeals for the Fifth Circuit	Texas v Azar (United States Affordable Care Act) Appeal decision of lower court that ruled the ACA unconstitutional due to the unconstitutionality of the individual mandate and inability to sever the mandate from the ACA.	In December 2018, a Texas District Court struck down the ACA in its entirety, finding that the 2017 Tax Cuts and Jobs Act, which reduced the penalty associated with the individual mandate to zero, renders the mandate unconstitutional, and invalidates the mandate as unconstitutional thus invalidates the entire ACA.	On July 9, 2019 the US Court of Appeals for the Fifth Circuit heard oral arguments on the District's Court's decision that the individual mandate is unconstitutional and not severable, it would invalidate the ACA and be appealed to the Supreme Court. The Supreme Court has already upheld the ACA as constitutional In December 2019, the U.S. Court of Appeals for the 5th Circuit affirmed the trial court's decision that the individual mandate is no longer constitutional because the associated financial penalty no longer "produces at least some revenue" for the federal government.[1] However, instead of deciding whether the rest of the ACA must be struck down, the 5th Circuit sent the case back to the trial court for additional analysis. The Supreme Court has agree to review the case. The Supreme Court will not expedite this decision, which means that, if the Court does take the case, it likely would be argued and decided in the next term and would not be resolved before the 2020 election.	Among other provisions of the ACA, this court case will impact Section 1557 which protects people who have preexisting conditions, prohibits discrimination based on race, color, national origin, sex, age, or disability. It will also impact the pathway for approval of generic copies of expensive biologic drugs.