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

September 10, 2020

TO: Dr. Steven Follansbee, President, and Members of the Health Service Board

FROM: Abbie Yant, RN, MA Executive Director SFHSS

RE: September 2020 Board Report

SFHSS is Operating in a Virtual Environment and is Closed to the Public

Announcement of the Competitive Bid for the Medical Plans for Plan Year 2022
SFHSS is preparing to issue a request for proposals (RFP) to competitively bid out our medical plans for active employees and early retirees (non-Medicare) in September 2020. The goal of the RFP supports the 5 strategic goals the SFHSS established in 2019.

Affordable and Sustainable Health Care Plans:
Acknowledge member costs (both through contributions and plan design) as well as the long-term financial sustainability of the overall program.

Reduce Plan Complexity and Fragmentation:
Select vendor partner(s) who provide comprehensive and integrated delivery systems.

Engage and Support SFHSS Members:
Identify vendor partner(s) who will promote health literacy and provide member advocacy, care coordination, and addresses racial equity and other social determinants of health (SDoH).

Choice and Flexibility:
Appreciate the various needs of members and provide meaningful opportunities in the areas of health plan, plan design, and network/health systems.

Whole Person Health and Well-Being:
Seek vendor partners who will support SFHSS's ongoing health and well-being activities, looks to shift from sick care to health care and reduces barriers to care e.g. SDoH.

The San Francisco Health Service System will issue a request for proposal (RFP) and conduct a competitive bid process to evaluate and select qualified health benefit organization partners for the 2022 plan year. The release date for the RFP will be no later than September 2020. SFHSS seeks proposals that will apply to our active employee Members, non-Medicare-eligible Members, and their dependents. The RFP will not include or affect the Medicare Retiree population plans including the UHC Medicare Advantage PPO plan, Kaiser Permanente Senior Advantage, or the Kaiser Multi-Region plans offered in Hawaii, Pacific Northwest, and Washington. The RFP will not include or affect the Kaiser Active and Early Retiree plan. Respondents to the RFP will be asked to propose solutions with similar health plan funding methods to our existing plan partners, including fully-funded, self-funded, and flex-funded models. SFHSS looks forward to evaluating and partnering with organizations to provide our Members with high-value benefits and improved health outcomes and to provide the City with long term, affordable, and sustainable health services.

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Vendor Black Out Period – Extended
The HSB approved the Vendor Black Out period commenced February 13, 2020. As of June 11, 2020, the vendor Black Out Period was extended through the rest of this calendar year to include the period for the Medical Plan selection process. Subsequently, SFHSS will be in negotiations with Medical, Dental, and Vision plan providers for Plan Year 2022 and therefore the Vendor Black Out Period will continue through June 2021.

Racial Equity Action Planning
I would like to share several updates about the ongoing work to address racial equity within our department, with our partners throughout the City, and with diverse stakeholders. The SFHSS General Fund Budget was presented to the Board of Supervisors, Special Budget, and Appropriations Committee mid-August. This presentation highlighted how our department is using the Racial Equity Action Plan framework to address disparities for communities of color and vulnerable populations as a part of the budgeting process. This Racial Equity Action Plan framework is being implemented city-wide as mandated by the Office of Racial Equity (ORE), a division of the San Francisco Human Rights Commission.

SFHSS's internal advisory committee is developing a new Annual Racial Equity Training Plan with evidenced-based approaches from national leaders in the field and insights gleaned from qualitative and quantitative all-staff survey input. This training plan will provide staff of all levels with diverse opportunities to engage in education that raises awareness about racial equity at the interpersonal, institutional, and structural levels. Racial Equity updates and quotes of the month are also being integrated into all-staff meetings so that employees can stay in-tuned with the latest developments to this ongoing work. At our August all-staff meeting we addressed the national protest concerning two police shootings of African American men in Wisconsin and Louisiana and encouraged staff to give attention to their emotional and mental health. The list of names of black lives affected and taken by systems of inequity in our police and criminal justice systems continues to grow. These recent tragedies remind us that the fight for racial equity is ongoing.

Lastly, SFHSS participated in the Pacific Business Group on Health (PBGH) Health Equities Survey. PBGH uses educational forums, user groups, and networking events to drive improvement throughout the healthcare system. PBGH highlighted our survey submission as being at the forefront of racial equity thinking and invited our Racial Equity Lead Leticia Pagán to speak to national private employers and public agencies at their September Quarterly Member Meeting. Presentation highlights included an overview of our two-fold Racial Equity Action Plan: Phase I involving work from the inside-out to build equitable employee workplaces that empower staff, Phase II highlighting how this ripple effect benefits the programs/services received by our membership and the health plan partnership we nurture to positively influence the delivery of care in support of health equity. This work connects to our cross stakeholder engagement efforts, our five Strategic Plan goals, and our key core value of inclusivity.

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Board Follow Up - Public Comment Feature
As a follow up to the Health Service Board and Governance Committee virtual meetings, SFHSS consulted the CCSF Department of Technology (DT) regarding the use of the contracted Webex platform for Public Comment. DT confirmed that the contracted use of the AT&T Public Comment Bridge (the previously used system) expired on July 31st, 2020. AT&T decided to retire the previous Public Comment system due to instability of the network which had failed city-wide on multiple occasions. AT&T launched a replacement service that DT chose not to adopt due to insufficient customer service.

SFHSS has adopted the use of the Webex platform as the available city-wide option endorsed by the CCSF Department of Technology. DT offers training and technical support for this system as it relates to hosting Board and Governance virtual meetings that include the Public Comment feature. DT does not provide training or technical support for meetings held on platforms outside of Webex. SFHSS will continue training to alleviate elevated technological issues, including those related to Public Comment specifically. These issues are not uncommon when migrating to a new platform such as this and SFHSS thanks the Board, staff, and members of the public for their patience and understanding. Step-by-step Public Comment instructions are publicly posted on the SFHSS Board website, broadcasted visually on SFGovTV, and read verbally for accessibility to all members. Questions or comments regarding Board meetings and the Public Comment feature specifically can be directed to health.service.board@sfgov.org

Attachments:

- SFHSS Division Reports
  - ESA Slide
  - Well Being Slides
- Finance Report
- Black Out Period Memo
- Audit Report
- HSB Email Procedures
- Legislative Report

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SFHSS DIVISION REPORTS: August 2020

PERSONNEL
Retirements:
Pamela Levin
As we announced in February, Pamela Levin, SFHSS Chief Financial Officer, is retiring as of October 31, 2020. Pamela began working in the public sector in 1982. Pamela has worked as a civil servant in various cities across the United States, and she began working with the City and County of San Francisco in 2000. After 13 years of working within the San Francisco City and County, Pamela was selected to be the Chief Financial Officer at SFHSS in 2013. During her tenure at SFHSS, Pamela has been instrumental in helping drive financial and operational improvements. On behalf of the entire Board, the Leadership Team, and the members, we thank Pamela for her dedication and valuable contributions over her 7-years at SFHSS. We wish her well as she begins her next journey at her new home in Santa Fe, New Mexico.

PERSONNEL
Welcome
A new (1654) Principal Accountant, Todd Creel starts in the department following the Labor Day weekend. This position was vacant due to the retirement of the previous Principal Accountant, Elizabeth Salazar. Todd has been with HSS during his internship and was most recently (1652) Accountant II at DPH.

Recruitments:
- 0931 Operations Manager: Currently accepting applications continuously
- 1813 Senior Benefits Analyst: Accepting applications 8/5 - 8/25
- 1210 Benefits Analyst – recruitment underway

Employees' Working Status:
- Due to Shelter-in-Place provisions, HSS employees have been performing a mix of duties in a variety of locations, including but not limited to essential HSS work both in the office and remotely and Disaster Service Assignments at various locations. There were/are times when work/resources are not available or staff are not available to perform assignments, but HSS is working to get access to work/resources for all employees.

WELL-BEING (see attached slides)
- Launched a city-wide employee well-being survey with 6,715 respondents representing 96% of city departments
- Offered telephonic coaching with a 100% booking rate resulting in a 78% show rate
- 20.6% increase in call volume for EAP services from the previous month
- Provided the first skill-building training (Be an Influencer! Strategies for Effective Communications) for the Well-Being Key Player Network with 60 in attendance
- 7.4% increase in downloads for the CORDICO Wellness App

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OPERATIONS

- Our offices remain closed to the public. We currently have three to four staff on-site Tuesdays and Fridays to perform essential work. During open enrollment, we will have up to seven staff on site.
- Member Services took 4300 calls in August. All customer service metrics were met. Call volume in August is in line with typical member interactions for this time of the year. Most of the calls were regarding new retiree questions, payments, and general member eligibility.
- Beginning in November, new employees and new retirees will be able to schedule an appointment with a benefits analyst for their benefits consultation.

Enterprise Systems & Analytics (ESA) (see attached slide)

- All aspects of Open Enrollment are the main focus for the ESA team at this point.
- Data files were released to the print vendor for the OE mailing.
- System configuration and programming is underway for numerous critical path items: eBenefits for SFUSD, automating attachment extracts from PeopleSoft to load into our digital member files, delivering a self-service identity verification system for SFUSD employees to register for eBenefits, providing scheduling solutions for flu shot clinics, configuring 2021 benefits programs, and writing audit queries and processing instructions to name a few.

Communications

- 11,140 website visitors and 51,569 page views of sfhss.org in August with more than 50% of top-visited pages promoted through eNews
- August eNews – 6,800 or 45% of subscribers opened the email.
- Completed 5 Booklets for Open Enrollment mailers
- Updated New Hires page for eBenefits online enrollment
- Collaborate on city-wide employee engagement campaign through SFCentral to promote 24/7 EAP
- Launched crisis push notifications through CORDICO for SFFD and SHF
- Conducted Influencer Communications training for Well-being Champions

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FINANCE DEPARTMENT
Budget and Procurement:

- FY 2019-20 year-end: Closed out the fiscal year and all concluding activities nearing an end. Moving to the year-end audit activities to produce the audit financial statements. Macias, Gini & O'Connell, LLP is the new auditing firm for this year's audit due to complete by the October Board meeting.
- FY 2020 -2021, FY 2021-2022: Biennial operating budget present to the Board of Supervisors and have not received any follow-up questions or requests for adjustments. Still pending approval.
- All Purchase, Work Orders, and other budgetary entries have been prepared and completed.

Finance Open Enrollment Support – PY2021

- Developing detailed subscriber-specific medical, dental, and vision rates for upload into PeopleSoft; these rates translate the approved rates into the actual rates that will be applied to employees, retirees, and dependents based on their respective eligibility, contribution levels, and enrolled plan(s).
- Executed amendment to the agreement with WORKTERRA for voluntary benefits administration
- Executed amendment to the agreement with Aon Consulting, Inc. for actuarial and health benefit consulting services
- Completed Chapter 12X (Banned State) reporting for the City Administrator for FY19-20
- Completed continuing authority reporting for personal services contracts with the Civil Service Commission FY19-20
- Issued Notice of Intent to Issue Request for Proposal (RFP) for Health Plans for Plan Year 2022
- Executed thirteen Mutual Confidentiality Agreements with prospective RFP respondents
- Reviewed 2021 plan year benefit guides, plan materials, and voluntary benefit offerings

Contracts Division

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Compliance

Completed FY1920 sole source memorandum to forward to the Board of Supervisors.
Completed SEC-126 vendor ethics forms for 2021 plan year agreements.

Enterprise Systems & Analytics Report

Project	Status	Key Accomplishments
Cybersecurity / Disaster Preparedness		• Completed HSS CCSF Risk Assessment • Met all deadlines to resolve critical issues identified by scans
eBenefits		• Self Service Identity Verification for SFUSD onboarding is in development • SFUSD custom pages for the OE eBenefits workflow have been completed and are in test
VOIP telephony upgrade		• Cisco Enterprise Contact Center solution tentative rollout Q3 ’20 has been delayed to Q4 or later due to redirected resources – Covid 19
Enterprise Content Management System (ECM) Business Insights / scanner licenses		• Attachment extract from PeopleSoft development request submitted • Functional specifications have been completed and this is moving into development
Open Enrollment		• Data files for OE mailing delivered to vendor 9/2
Athena Penelope EAP software		• Go-live anticipated for November 1 • Implementation phase in progress
CredibleMind (expert-rated resources related to mental health / well-being		• Kick-off with vendor on 7/29 • 9/4 meeting on technical specifications

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

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

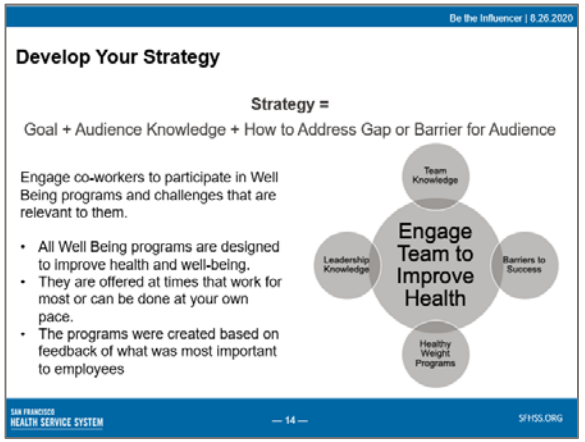
 Serious issues. Project most likely delayed or significant budget overrun

Well-Being Monthly Report

Health Service Board Meeting | September 10, 2020

Well-Being@Work: Be an Influencer! Strategies for Effective Communications

- ✓ One virtual training – August 26, 2020
- ✓ Attendance: 60 Champions and Department Leads
- ✓ Goals of the workshop:
  1. Approach communications with an end goal in mind
  2. Determine who is the most important audience
  3. Persuasive ways to gain support
  4. Techniques to engage your colleagues



Well-Being@Work: COVID-19 Well-Being Survey Results

A citywide survey was shared with employees. The goal of the survey was to identify opportunities to bring new and relevant resources and programs to support employee's well-being during the pandemic. Survey results are shared with departments during the Well-Being@Work Annual Plan check-ins.

- Survey Categories:
  - Current work status
  - Department supports
  - Mental/emotional health
  - Well-being interests
- 6,715 participants
- 96% of departments represented

Well-Being@Work: COVID-19 Well-Being Survey Results

Summary of Key Findings:

- ✓ 44% indicated their level of team engagement and work productivity has increased or remained the same while telecommuting.
- ✓ 51% agreed that their organization is supporting them in their mental health and well-being during the COVID-19 pandemic response phase.
- ✓ 59% of employees indicated that in the past 30 days their level of stress is between a 7-10 (0 is no stress and 10 is extremely high stress).
  - ✓ CCSF weighted score: 7.5
- ✓ Top three concerns related to COVID-19:
  - ✓ Health of family members (49%)
  - ✓ Personal health – contracting COVID-19 (29%)
  - ✓ Uncertainty of the what future will look like (25%)

Well-Being@Work: COVID-19 Well-Being Survey Results

Next Steps:

- ✓ Build out department reports and review with departments
- ✓ Identify what of the current resources are being valued
- ✓ Identify gaps of new resources/tools/offerings to support employee well-being
- ✓ Deeper dive into data analysis on mental health and identify gaps
- ✓ Build out a city-wide report
- ✓ Pull first responder department data together to analyze – identify common themes and build out a schedule of Cordico push notifications

Highlights: Virtual Offerings

4 Coaching Days

100% booking rate with 78% show rate

Coaching survey highlights:

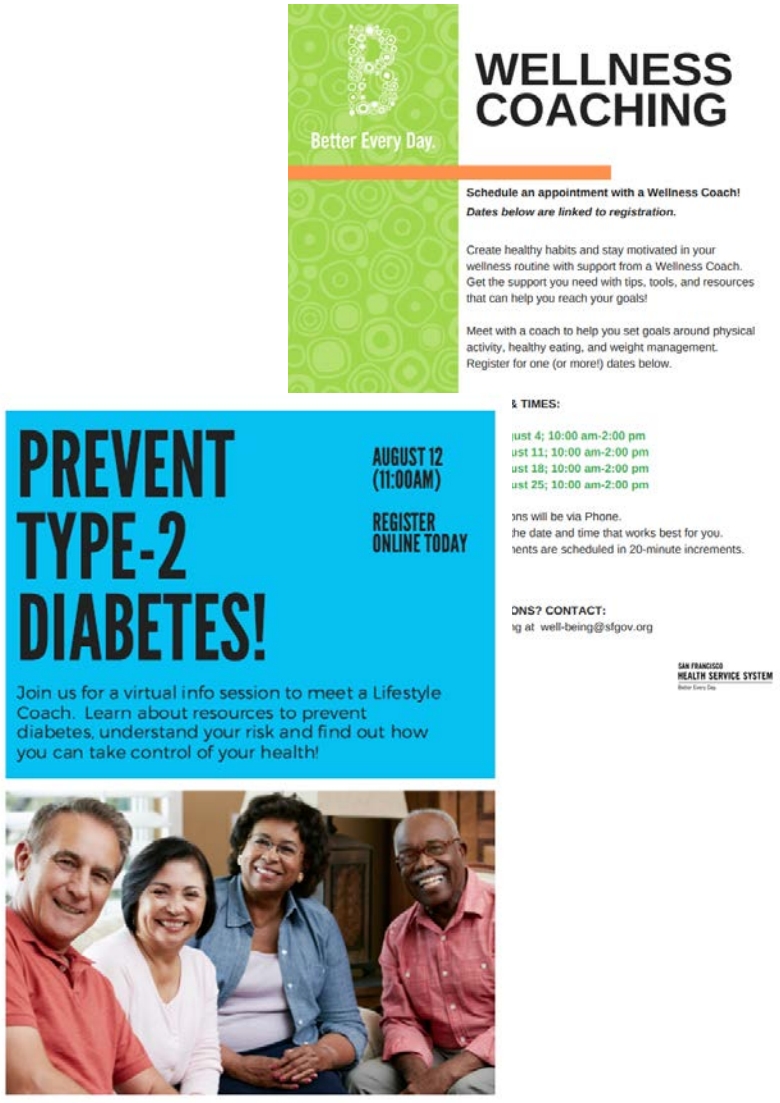
- 60% first-time working with a Wellness Coach
- 87% are confident they can make a behavior change based on the action plan/goal they set with the coach
- 94% are likely to participate in another wellness coaching session

Diabetes Prevention Program: *Informational Session*

Total Participants: 27

Meeting highlights:

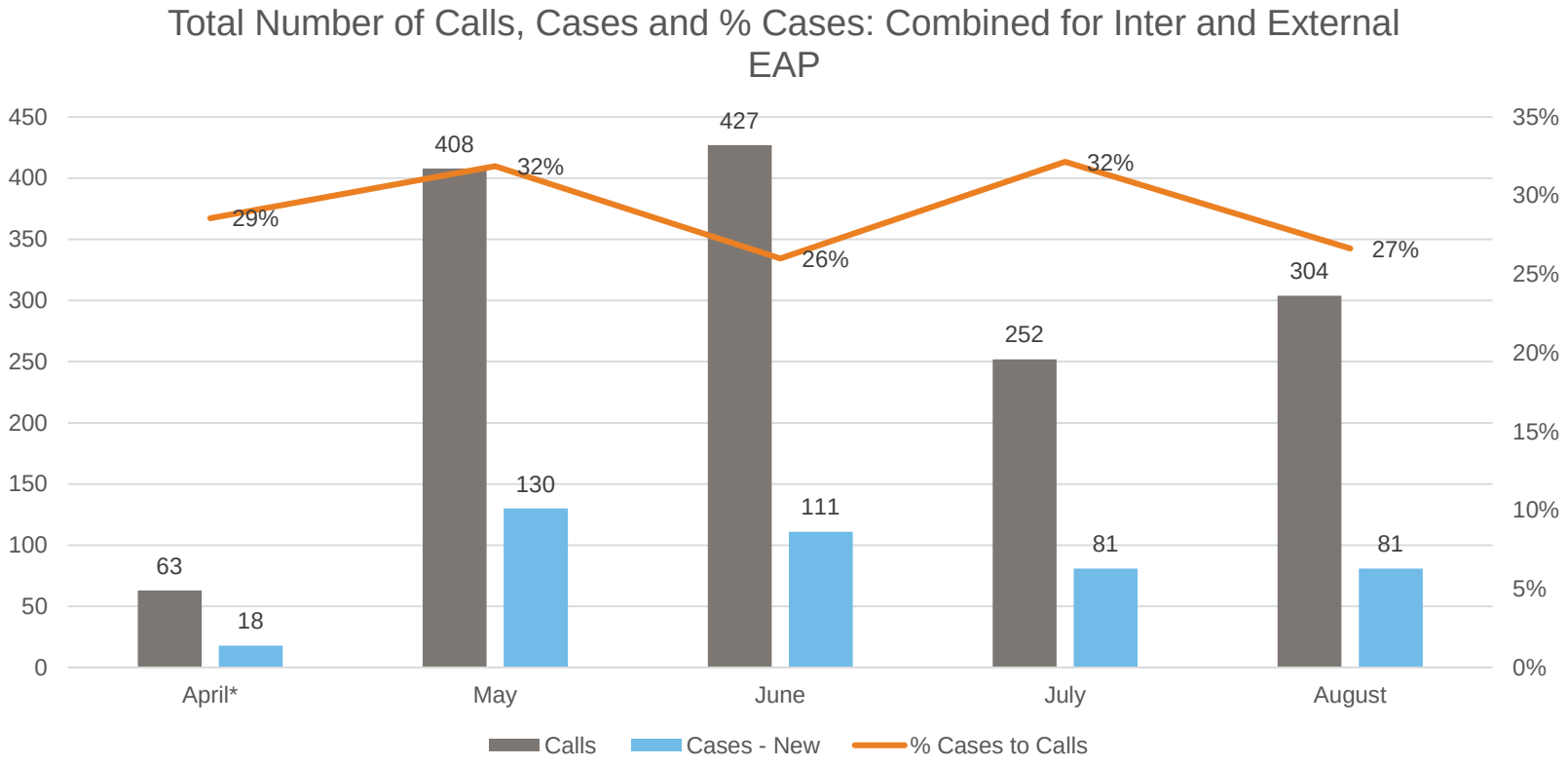
- Understand risk for diabetes
- Meet the Coach
- Learn about the Diabetes Prevention Program
- Weight management resources



EAP Call Volume Increased by 20.6% from Previous Month

External 24/7 EAP + SFHSS Internal EAP

- 42% of all calls fall on Monday and Tuesday of the week



**Represents only External 24/7 EAP from 4/24 (inception) through 4/30*

External 24/7 EAP

(Data represents 4/24 through 8/31/2020)

- 22% of all calls to EAP occur between 5 pm and 8 am
- 23% of presenting issues are stress related
- 14% of all services are from first responders
- Individuals between the ages of 31- 50 represent the highest number of callers (61%)

SFHSS Internal EAP

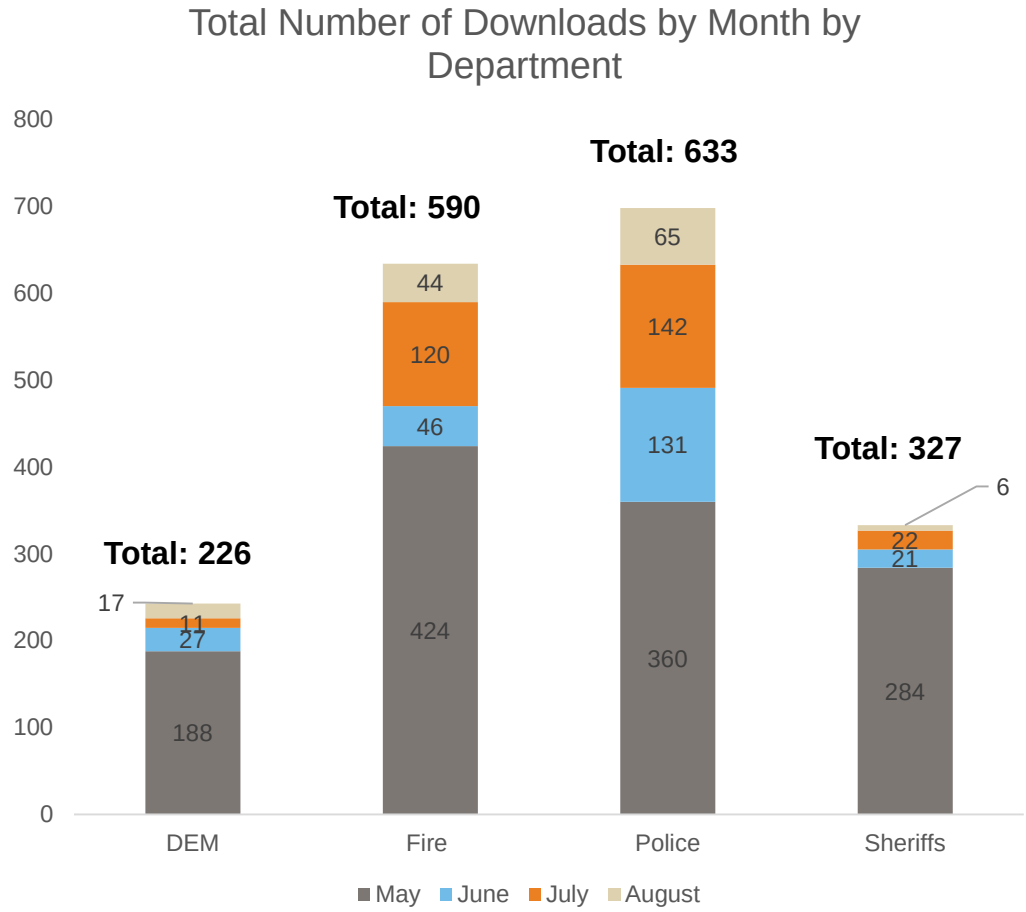
Organizational Services

- 7 critical incident responses serving 256 people *(May 1, 2020 through August 31, 2020)*
- 114 organizational consultations
- 15 group sessions offered (July – August), serving 33 people

Behavioral Health: Cordico Wellness App

- Total downloads as of 8/28 (DEM, FIR, POL, SHF): 1908 (7.4% increase from July)

- Employee Headcount
  - DEM: 302
  - FIR: 1818
  - POL: 3064
  - SHF: 1054
- New Modules Added:
  - Dr. Gilmartin Videos – SFPD, DEM, SHF
  - Donations – SFPD
  - Back to School Resources – SHF
- Top 5 Modules:
  1. Wellness Toolkit (15,801 clicks)
  2. Peer Support/BSU/Stress Unit (4,745 clicks)
  3. COVID-19 Resources (2,478 clicks)
  4. Self Assessment (1,931 clicks)
  5. Fitness, Nutrition and Injury Prevention (1,648 clicks)



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Memorandum

DATE: September 10, 2020

TO: Dr. Stephen Follansbee, President and Members of the Health Service Board

FROM: Larry Loo, Chief Financial Officer

RE: Financial Report as of June 30, 2020

This report summarizes revenues and expenses of the Employee Benefit Trust Fund (Trust Fund) and the General Fund Administration Budget for twelve months of FY 2019-20 as of June 30, 2020. These are based on the unaudited financial statements. The balances may be adjusted when the final year-end close activities are made as a result of the annual financial audit. The final audited financials are scheduled to be released in October and presented to the Health Service Board (Board) in December.

Executive Summary

Trust Fund

- Projecting a $23.6 million increase in the fund balance, from $92.2 million on June 30, 2019 to $115.8 on June 30, 2020

- Fiscal Year Projected change in fund balance by plan
  - UHC PPO: $0.3 M projected increase, due to modest claim suppression in calendar Q2-2020
  - Blue Shield Access +: $13.7 M projected increase primarily due to continued claims suppression experience and pharmacy rebates
  - Blue Shield Trio: $3.1 M projected decrease primarily due to unfavorable claims experience

- Cumulative expenses compared to revenues with twelve months of experience by plan
  - UHC PPO: cumulative expenses tracking $0.37 M less than revenues
  - Blue Shield Access +: cumulative expenses tracking $11.57 M less than revenues
  - Blue Shield Trio: cumulative expenses tracking $2.73 M more than revenues
  - Delta Dental Sell-Funded plan: cumulative expenses tracking $14.09 M less than revenues

- Healthcare Sustainability Fund: $4.3 M projected balance

- Interest: $2.1 M projected increase in fund balance

- Performance guarantees: $0.3 M received year-to-day date

- Pharmacy Rebates: $7.6 M received year-to-date

General Fund

- Projecting $0.46 M year-end balance

Employee Benefit Trust Fund

On June 30, 2019, the audited Trust Fund balance was $92.2 million. Based on activity through twelve months ending June 30, 2020, the fiscal year end fund balance is projected to be $115.8 million. The projected $23.6 million increase includes reserves for unpaid claims.

During the first half of calendar year 2020, the COVID-19 pandemic has greatly impacted the United States health care landscape – particularly starting in March 2020. The number of COVID-19 cases in the United States, including the San Francisco Bay Area, continues to escalate. It is unclear when virus infection rates will diminish. There are many uncertainties associated with the impact of COVID-19 on employer health care claims costs. In addition to direct COVID-19 expenditures due to member testing for and treatment of COVID-19, elective procedures and non-emergency health care services have been deferred by members in recent months, resulting in substantial changes to the types and frequency of claims incurred by members of employer-sponsored plans in recent months, versus prior to the pandemic.

As a result, lower levels of health care claim experience in SFHSS plans have been seen starting in March 2020, though degrees of claim suppression vary by plan. Dental plans have seen higher levels of claim suppression since March 2020 than medical plans, as many dental practices closed during stay-at-home and shelter-in-place orders especially in the April 2020 and May 2020 time periods.

The following table summarizes the projected changes in fund balance.

	Change in Fund Balance (in millions)	Page
United Health Care PPO Plan	$ 0.3	3
Blue Shield Access+ Flex-Funded Plan	13.7	4
Blue Shield Trio Flex-Funded Plan	(3.1)	5
Delta Dental Self-Funded Plan	8.2	6
Fully Insured/ Health Care Sustainability Fund	2.2	7
Interest	2.1	7
Performance Guarantees	0.3	7
Performance Guarantees – Surrogacy and Adoption Assistance Plan	(0.1)	7
Forfeitures	0.4	7
Transfers Out	(0.4)	7
Total	$ 23.6	

Pharmacy Rebates are discussed on page 8.

United Health Care PPO (City Plan)

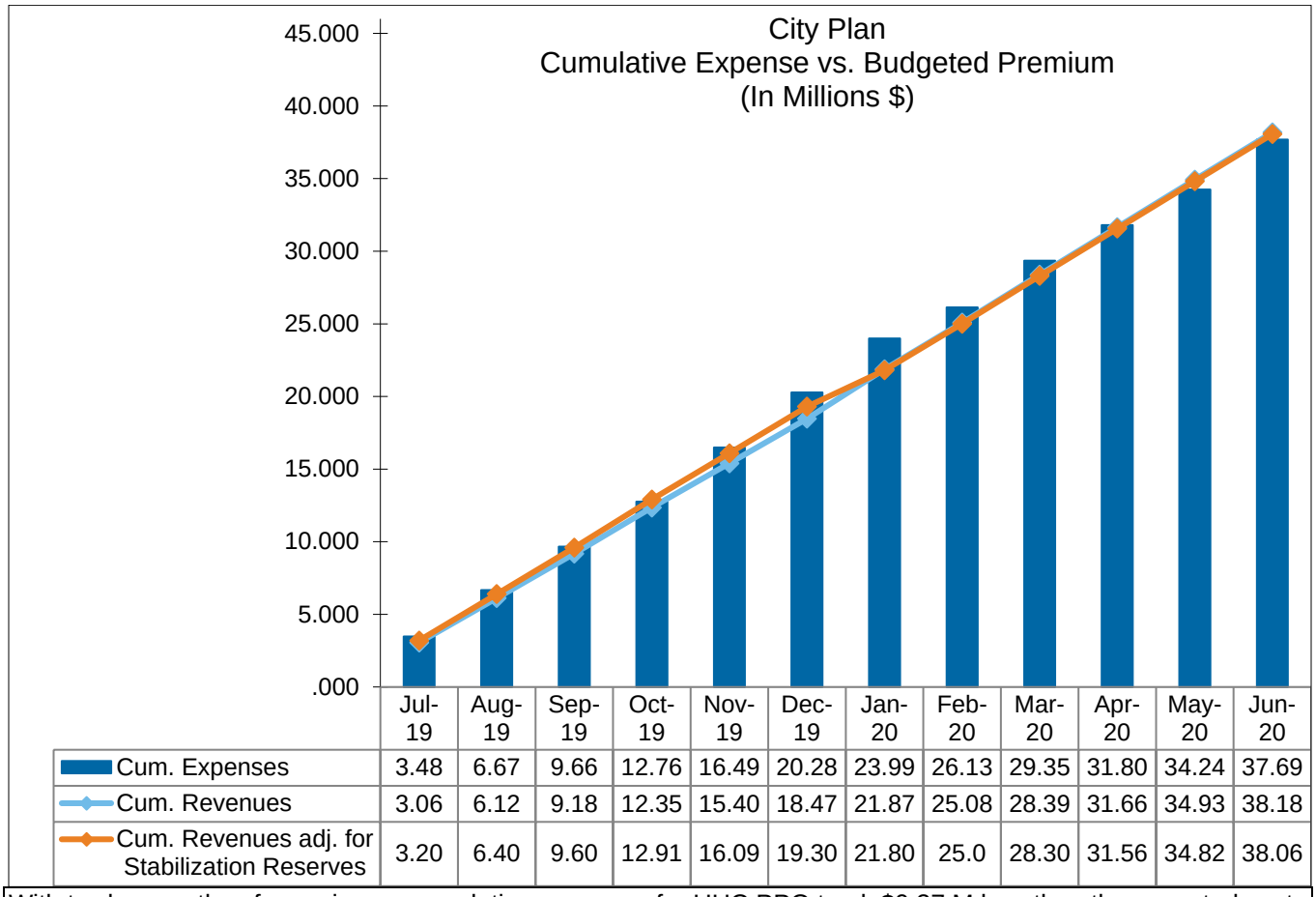
Fiscal Year End Projection

A $0.3 million increase in fund balance is projected as a result of the following:

a. $0.8 million decrease in fund balance:
   - $0.8 million associated with subsidizing 2019 rates (for the first six months of FY 2019-20) from the 2017 year-end claim stabilization reserve

b. $1.1 million increase in fund balance:
   - $0.1 million associated with the increase in 2020 rates (for the second six months of FY 2019-20) due to rating buy-up of the 2018 year-end claims stabilization deficit
   - $1.0 million of pharmacy rebates (additional information on page 8)

Experience Through Twelve (12) Months



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Cum. Expenses	3.48	6.67	9.66	12.76	16.49	20.28	23.99	26.13	29.35	31.80	34.24	37.69
Cum. Revenues	3.06	6.12	9.18	12.35	15.40	18.47	21.87	25.08	28.39	31.66	34.93	38.18
Cum. Revenues adj. for Stabilization Reserves	3.20	6.40	9.60	12.91	16.09	19.30	21.80	25.0	28.30	31.56	34.82	38.06

With twelve months of experience, cumulative expenses for UHC PPO track $0.37 M less than the expected cost levels regardless of whether cumulative expenses are compared to the actual revenues ($37.69 M - $38.06 M) and when the cumulative expenses are compared to cumulative revenues with the $0.12 M buyup for the rate stabilization reserves ($37.69 M – ($38.18 M - $0.12 M)).

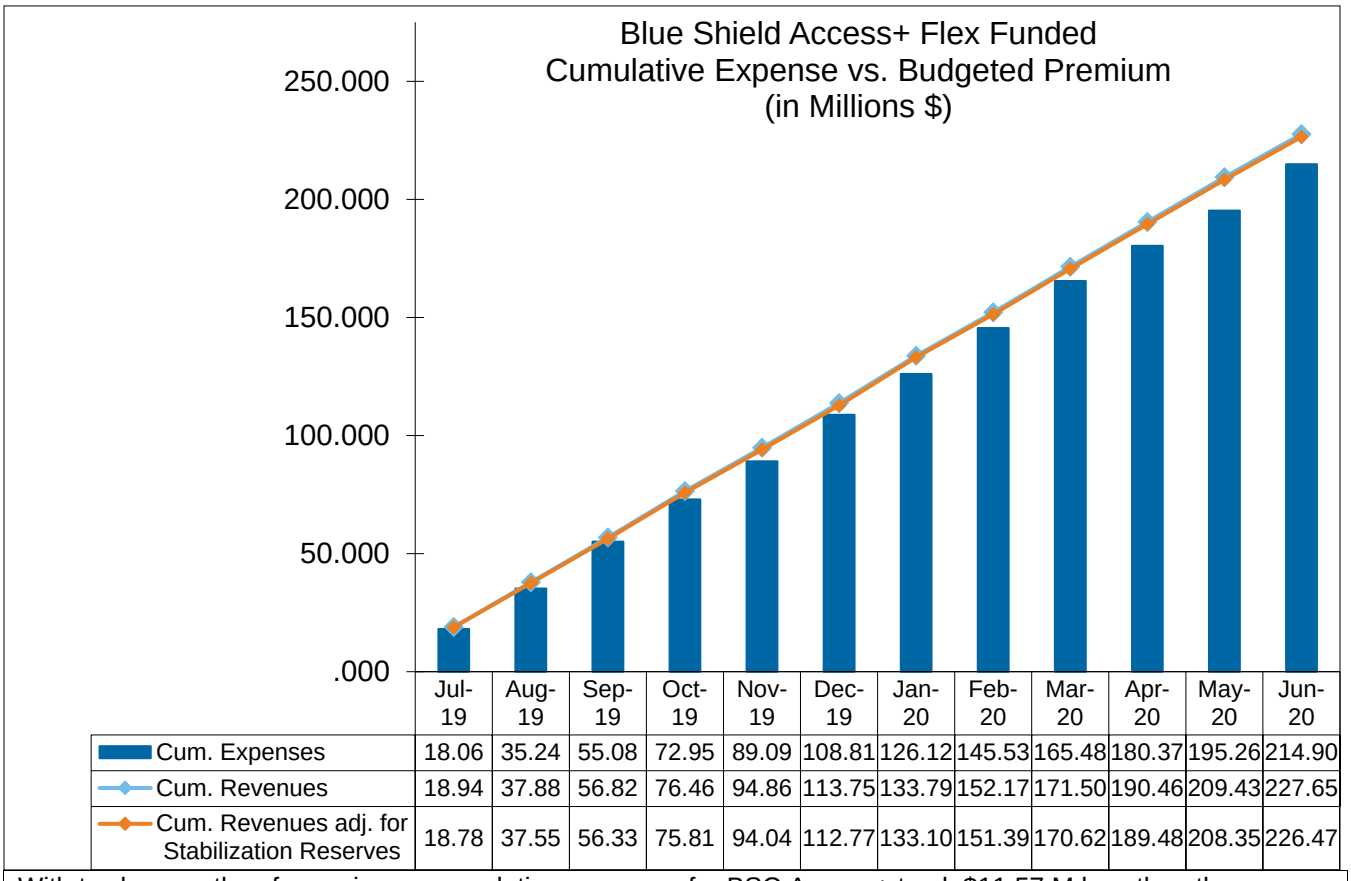
Blue Shield Access+ Flex Funded Plan

Fiscal Year End Projection

A $13.7 million increase in fund balance is projected resulting from:

- $1.0 million associated with the increase in 2019 rates (for the first six months of FY 2019-20) to recover the 2017 year-end claim stabilization reserve
- $0.6 million associated with the increase in 2020 rates (for the second six months of FY 2019-20) from the 2018 year-end claim stabilization reserve
- $4.8 million of pharmacy rebates (additional information on page 8)
- $7.3 million due to favorable claim experience.

Experience Through Twelve (12) Months



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Cum. Expenses	18.06	35.24	55.08	72.95	89.09	108.81	126.12	145.53	165.48	180.37	195.26	214.90
Cum. Revenues	18.94	37.88	56.82	76.46	94.86	113.75	133.79	152.17	171.50	190.46	209.43	227.65
Cum. Revenues adj. for Stabilization Reserves	18.78	37.55	56.33	75.81	94.04	112.77	133.10	151.39	170.62	189.48	208.35	226.47

With twelve months of experience, cumulative expenses for BSC Access+ track $11.57 M less than the expected cost levels regardless of whether cumulative expenses are compared to the actual revenues ($214.90 M – $226.47 M) and when the cumulative expenses are compared to the cumulative revenues with the $1.18 M buy-up for the rate stabilization reserves ($214.90 M – ($227.65 - $1.18 M).

Blue Shield Trio Flex-Funded Plan

Fiscal Year End Projection

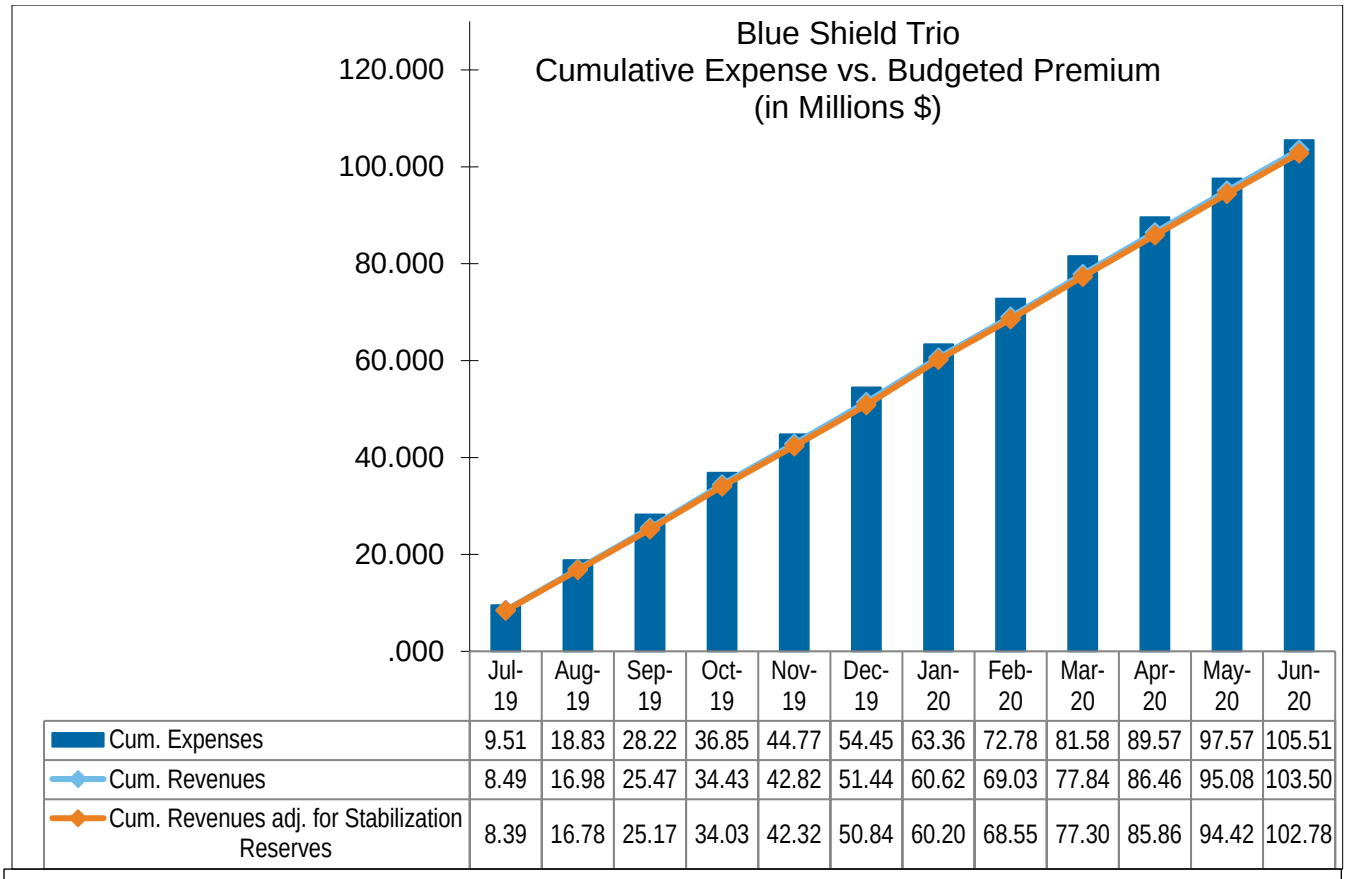
A $3.1 million decrease in fund balance is projected resulting from:

a. $2.8 million increase in fund balance:

- $0.6 million associated with the increase in 2019 rates (for the first six months of FY 2019-20) to recover the 2017 deficit
- $0.3 million associated with the increase in 2020 rates (for the second six months of FY 2019-20) to recover the 2018 deficit
- $1.9 million in pharmacy rebates (additional information on page 8)

$5.9 million decrease in fund balance due to unfavorable claim experience.

Experience Through Twelve (12) Months



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Cum. Expenses	9.51	18.83	28.22	36.85	44.77	54.45	63.36	72.78	81.58	89.57	97.57	105.51
Cum. Revenues	8.49	16.98	25.47	34.43	42.82	51.44	60.62	69.03	77.84	86.46	95.08	103.50
Cum. Revenues adj. for Stabilization Reserves	8.39	16.78	25.17	34.03	42.32	50.84	60.20	68.55	77.30	85.86	94.42	102.78

Based on twelve months of experience, cumulative expenses for BSC Trio are $2.73 M more than the expected cost levels regardless of whether cumulative expenses are compared to the actual revenues105.51 M – $102.78 M) and when cumulative expenses are compared to cumulative revenues with the $0.72 M buy up for the rate stabilization reserves ($105.51 M – ($103.50 M - $0.72 M).

Delta Dental Self-Funded Plan

Fiscal Year End Projection

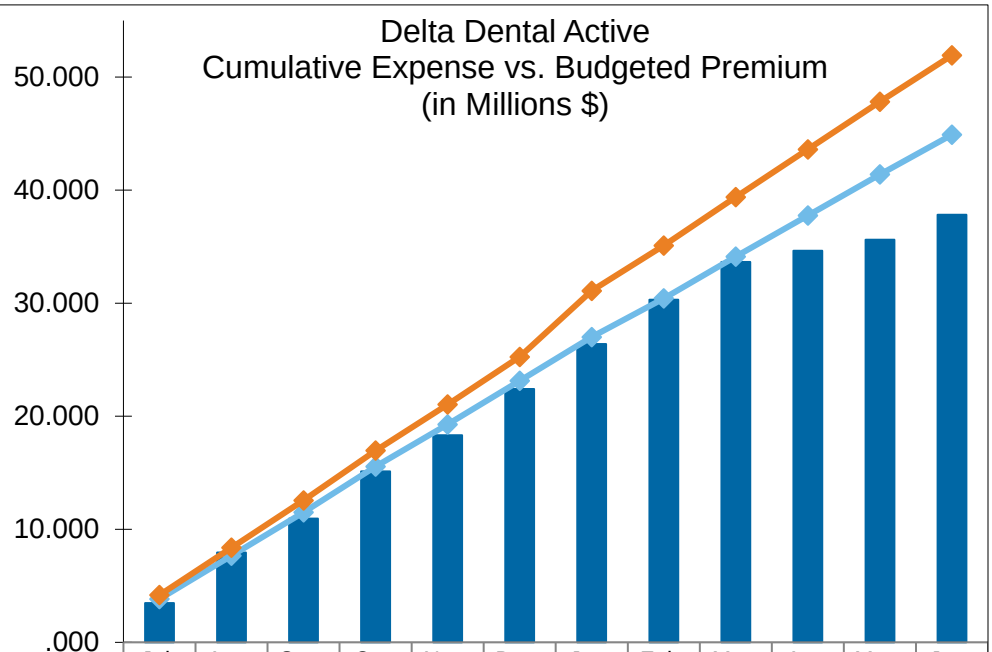
A $ 8.2 million change in fund balance is projected:

a. $13.8 million increase in fund balance due to favorable claim experience. This is primarily due claims suppression resulting from COVID-19. Dental offices were not taking patients for elective services during the first three months of the pandemic.

b. $5.6 million decrease in fund balance:

- $2.1 million decrease in fund balance associated with subsidizing 2019 rates (for the first six months of FY 2019-20) from the claim stabilization reserve
- $3.5 million decrease in fund balance associated with subsidizing 2020 rates (for the second six months of FY 2019-20) from the claim stabilization reserve

Experience Through Twelve (12) Months



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Cum. Expenses	3.47	7.95	10.94	15.12	18.32	22.41	26.39	30.31	33.65	34.63	35.62	37.83
Cum. Revenues	3.83	7.67	11.50	15.55	19.28	23.14	27.01	30.42	34.12	37.76	41.39	44.90
Cum. Revenues adj. for Stabilization Reserves	4.18	8.37	12.56	16.96	21.04	25.25	31.10	35.10	39.39	43.60	47.82	51.92

Based on twelve months of experience, cumulative expenses for Delta Dental are $14.09 M less than the expected cost levels regardless of whether the cumulative expenses are compared to actual revenues ($37.83 M – $51.92 M) and when cumulative expenses are compared with cumulative revenues with the $7.02 M buy down from the rate stabilization reserve ($37.83 M – ($44.90 M + $7.02 M)).

Other Trust Fund Notes

Healthcare Sustainability Fund

With twelve (12) months of actuals, a projected positive balance of $4.3 million is expected at the end of FY 2019-20.

Healthcare Sustainability Fund FY 2019-20			
	Revised Budget	June YTD Actual	Variance
Revenues/Premiums			
Annual Revenues	$ 2,602,555	$ 2,563,606	$ (38,949)
Carryforward from fund balance	3,080,176	3,909,772	$ 829,596
Total	$ 5,682,731	$ 6,473,378	$ 790,647
Expenditures			
Annual Expenditures	$ 2,676,868	$ 1,793,006	$ 883,862
One-time Expenditures	2,215,436	406,994	$ 1,808,442
Grand Total Expenditures	$ 4,892,304	$ 2,200,001	$ 2,692,303
Balance	$ 790,427	$ 4,273,377	$ 3,482,950

Interest

An $2.1 million increase in fund balance is projected based on the Trust Fund cash balances for FY 2019-20.

Performance Guarantees

Three hundred thousand ($0.31 million) in performance guarantees have been received in FY 2019-20. The $92.2 million fund balance as of June 30, 2019 includes the $8.3 million in PGs received since FY 2005-06.

Performance Guarantees for Adoption and Surrogacy Assistance Plan

Performance guarantees are used to fund the Adoption and Surrogacy Assistance Plan. As of June 30, 2020, $94,500 has been reimburse to members.

Forfeitures and Transfers Out

The IRS allows forfeitures from flexible spending accounts to be used to fund the administration of the accounts. Since the funding for the administration is in the General Fund and the forfeitures reside in the Trust, a transfer needs to be made at the close of each fiscal year. In FY 2019-20, $0.40 million is projected in forfeitures which will be transferred to the General Fund budget. This is $0.20 million less than what was budgeted in the General Fund.

Pharmacy Rebates

The following table summarizes the FY 2019-20 pharmacy rebates as of June 30, 2020 and year-end projection. The rebates are provided at the end of each quarter. As of June 30, 2020, $7.6 million of pharmacy rebates has been received. The rebates offset the claims payments to the plans.

Vendor	Amount (year to date)
Blue Shield	$6,660,000
UHC	$ 960,000
Total	$7,620,000

GENERAL FUND ADMINISTRATION BUDGET

FY 2019-20

Based on the financial results for the first twelve months of FY 2019-20, a balance of $463,836 is projected at the end of FY 2019-20. The carryforward requests submitted to the Controller's and Mayor's Office in August and approval is expected in late September.

FY 2020-21

The Mayor's Proposed FY 2020-21 and FY 2021-22 budget for SFHSS did not change during the Budget and Appropriations Committee meetings in August. The budget will be considered by the full Board of Supervisors in September.

Health Service System
CITY & COUNTY OF SAN FRANCISCO

HEALTH SERVICE SYSTEM
STATEMENT OF REVENUES AND EXPENSES
FY 2019-2020
FOR THE TWELVE MONTHS ENDED June 30, 2020

ACTIVE & RETIRED COMBINED

		Year-To-Date Revenues	Year-To-Date Expenses	Year-To-Date Net Excess(Shortage)	
1	**SELF-INSURANCE**				1
2	UHC PPO, including ASO *	38,178,157	37,689,237	488,920	2
3	Blue Shield Access+ *	227,645,392	214,901,399	12,743,993	3
4	Blue Shield Trio *	103,501,830	105,511,720	(2,009,890)	4
5	Delta Dental - Active only, including ASO	44,903,871	37,826,627	7,077,244	5
6	**TOTAL SELF-INSURANCE**	**414,229,250**	**395,928,983**	**18,300,267**	6
7					7
8	**INSURANCE PRODUCTS**				8
9	UHC MAPD	79,343,961	79,343,961	0	9
10	Kaiser-HMO	438,972,972	438,678,651	294,321	10
11	Vision Service Plan, All (City Plan & HMO)	8,331,768	8,334,377	(2,608)	11
12	Sub-total HMO	526,648,702	526,356,989	291,713	12
13					13
14	Delta Dental - Retired	16,320,460	16,320,460	-	14
15	Delta Care	858,118	860,111	(1,993)	15
16	UHC Dental	453,645	436,082	17,563	16
17	Sub-total Dental	17,632,223	17,616,653	15,570	17
18					18
19	Long Term/Short Term Disability	7,170,227	7,043,964	126,263	19
20	Flexible Benefits	2,965,713	2,965,530	183	20
21	Flexible Spending-Dependent Care	5,514,942	5,319,999	194,943	21
22	Flexible Spending -Medical Reimbursement	8,724,936	7,492,617	1,232,319	22
23	Best Doctors ($1.15)	487,668	486,169	1,499	23
24	Healthcare Sustainability Fund ($3.00)	2,563,606	2,189,613	373,993	23
25	Adoption & Surrogacy		94,500	(94,500)	25
26	**TOTAL INSURANCE PRODUCTS**	**571,708,016**	**569,566,035**	**2,141,982**	26
27					27
28	**SAVINGS AND INVESTMENTS**				28
29	Interest	2,109,075		2,109,075	29
30	Performance guarantees	317,814	-	317,814	30
31	Forfeitures	404,074		404,074	31
32	**TOTAL SAVINGS & INVESTMENTS**	**2,830,963**		**2,830,963**	32
33					33
34	**TRANSFERS OUT OF FORFEITURES**		**404,074**	**(404,074)**	34
35					35
36	**TOTAL FUNDS**	**988,768,230**	**965,899,091**	**22,869,138**	36

* Expenses are net of pharmacy rebates - see report for details

SUMMARY- In millions	**FY19-20** Year-To Date Actual As of June 2020 - Net (Pre-Audit)	**FY19-20** Projected Annual-Net	
Self Insurance			
UHC PPO	0.5	0.3	(a)
Blue Shield-Access+	12.7	13.7	(b)
Blue Shield-Trio	(2.0)	(3.1)	(b)
Dental, Actives	7.1	8.2	(c)
Insurance Products			
Medical HMOs	0.3	0.3	
Dental	0.0	0.0	
LTD/Flexible Benefits/FSA/Best Doctors	1.6	1.6	
Healthcare Sustainability Fund ($3.00)	0.4	0.4	(d)
Savings & Investments			
Interest	2.1	2.1	
Performance guarantees	0.3	0.3	(e)
Performance guarantees - Surrogacy and adoption	(0.1)	(0.1)	(f)
Forfeitures	0.4	0.4	
Transfers Out	(0.4)	(0.4)	(g)
TOTAL	22.9	23.6	
Net assets			
Beginning of the year		92.2	
End of the year		115.8	

(a) Annual Projection is net of claim stabilization of $0.8 million used to reduce 2019 rates, $0.1 million to increase 2020 rates, and Pharmacy rebate of $1 million

(b) Annual Projection is net of claim stabilization of $1.6 million to increase 2019 rates, $0.9 million to increase 2020 rates, and Pharmacy rebate of $6.7 million

(c) Annual Projection is net of claim stabilization of $2.1 million to reduce 2019 rates and $3.5 million to reduce 2020 rates

(d) $3.00 per member per month for communications, wellness, actuarial work; is part of a total premium.

(e) Only reflects performance guarantees received in FY 2019-2020

(f) Reflects use of fund balance

(g) Transfer of $0.4M from forfeitures to General Fund per FY 2019-2020 budget

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

SAN FRANCISOC HEALTH SERVICE SYSTEMS
STATEMENTS OF REVENUES AND EXPENSES
FY2019-2020 VS FY2018-2019
YEAR-TO-DATE: JUNE 30, 2020

	For 12 months ended June 30, 2020	For 12 months ended June 30, 2019	$ Change	% Change	
SELF-INSURANCE					
UHC PPO, including ASO					
Revenues	38,178,157	34,685,565	3,492,593	10.1%	l
Expenses	(37,689,237)	(38,270,669)	581,432	-1.5%	
Net UHC PPO Excess(Shortage)	488,920	(3,585,105)	4,074,025	-113.6%	
Blue Shield-Access+					
Revenues	227,645,392	211,790,615	15,854,777	7.5%	p
Expenses	(214,901,399)	(204,643,724)	(10,257,674)	5.0%	p
Net Blue Shield-Access Excess(Shortage)	12,743,993	7,146,891	5,597,103	78.3%	
Blue Shield-Trio					
Revenues	103,501,830	106,873,402	(3,371,572)	-3.2%	p
Expenses	(105,511,720)	(101,396,058)	(4,115,661)	4.1%	p
Net Blue Shield-Trio Excess(Shortage)	(2,009,890)	5,477,344	(7,487,234)	-136.7%	
Delta Dental - Active only, including ASO					
Revenues	44,903,871	46,941,720	(2,037,849)	-4.3%	h
Expenses	(37,826,627)	(45,707,658)	7,881,030	-17.2%	j
Net Delta Dental - Active Excess(Shortage)	7,077,244	1,234,062	5,843,181	473.5%	
NET SELF-INSURANCE	**18,300,267**	**10,273,192**	**8,027,076**	**78.1%**	
INSURANCE PRODUCTS					
Kaiser-HMO					
Revenues	438,972,972	421,376,089	17,596,883	4.2%	d, l
Expenses	(438,678,651)	(420,585,881)	(18,092,770)	4.3%	d, l
Net Kaiser- HMO Excess(Shortage)	294,321	790,208	(495,887)	-62.8%	
UHC MAPD					
Revenues	79,343,961	70,707,656	8,636,305	12.2%	d, l
Expenses	(79,343,961)	(70,707,656)	(8,636,305)	12.2%	d, l
Net UHC MAPD Excess(Shortage)	0	0	0		
Vision Service Plan, All (City Plan & HMO)					
Revenues	8,331,768	7,571,857	759,911	10.0%	o
Expenses	(8,334,377)	(7,563,412)	(770,964)	10.2%	o
Net Vision Service Plan Excess(Shortage)	(2,608)	8,445	(11,053)		
Delta Dental - Retired					
Revenues	16,320,460	15,540,980	779,480	5.0%	d
Expenses	(16,320,460)	(15,556,411)	(764,050)	4.9%	d
Net Delta Dental - Retired Excess(Shortage)	0	(15,431)	15,431	-100.0%	
Delta Care					
Revenues	858,118	887,537	(29,419)	-3.3%	a
Expenses	(860,111)	(886,588)	26,476	-3.0%	a
Net Delta Care Excess(Shortage)	(1,993)	949	(2,942)	-309.9%	
UHC Dental					
Revenues	453,645	418,452	35,193	8.4%	d, h
Expenses	(436,082)	(417,839)	(18,243)	4.4%	d, h
Net UHC Dental Excess(Shortage)	17,563	614	16,950	2762.2%	
Net Dental	15,570	(13,868)	29,438	-212.3%	
Long Term/Short Term Disability					
Revenues	7,170,227	7,550,359	(380,133)	-5.0%	h
Expenses	(7,043,964)	(7,550,359)	506,395	-6.7%	h
Net Long Term/Short Term Disability Excess(Shortage)	126,263	0	126,263		
Flexible Benefits					
Revenues	2,965,713	2,574,003	391,709	15.2%	g
Expenses	(2,965,530)	(2,573,930)	(391,600)	15.2%	g
Net Flexible Benefits Excess(Shortage)	183	74	109	0.0%	
Flexible Spending-Dependent Care					
Revenues	5,514,942	5,285,021	229,921	4.4%	d
Expenses	(5,319,999)	(5,151,046)	(168,954)	3.3%	f
Net Flexible Spending-Dependent Care Excess(Shortage)	194,943	133,975	60,967	45.5%	
Flexible Spending -Medical Reimbursement					
Revenues	8,724,936	7,665,082	1,059,854	13.8%	d
Expenses	(7,492,617)	(8,020,700)	528,084	-6.6%	j
Net Flexible Spending-Medical Reimbursement Excess(Shortage)	1,232,319	(355,619)	1,587,938	-446.5%	
Best Doctors ($1.15)					
Revenues	487,668	1,115,061	(627,393)	-56.3%	b
Expenses	(486,169)	(1,069,484)	583,315	-54.5%	b
Net Best Doctors Excess(Shortage)	1,499	45,577	(44,078)		
Adoption & Surrogacy					
Expenses	(94,500)	(111,198)	16,698	-15.0%	
Healthcare Sustainability Fund ($3.00)					
Revenues	2,563,606	2,541,882	21,724	0.9%	
Expenses	(2,200,001)	(2,031,927)	(168,074)	8.3%	e
Net Healthcare Sustainability Fund ($3.00) Excess(Shortage)	363,605	509,955	(146,350)	-28.7%	
NET INSURANCE PRODUCTS	**2,131,594**	**1,007,550**	**1,124,044**	111.6%	
SAVINGS AND INVESTMENTS					
Interest	2,109,075	2,030,885	78,190	0.0%	
Performance guarantees	317,814	510,701	(192,887)	-37.8%	
TOTAL SAVINGS & INVESTMENTS	**2,426,889**	**3,429,061**	**(114,697)**	-3.3%	
TOTAL NET EXCESS (SHORTAGE)	**22,858,750**	**14,709,803**	**9,036,423**	61.4%	

Notes: a decrease in membership
b discontinued on 1/1/20
c decrease in deductions
d increase in membership
e $3 per member per month for communications, wellness, actuarial work
f increase in claims
g increase in deductions
h decrease in rates
j decrease in claims
l increase in rates
o vision buy-up effective 1/1/18
p effective 1/1/18

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

Healthcare Sustainability Fund FY 2019-20

	Revised Budget	June YTD Actual	Variance
Revenues/Premiums			
Annual Revenues	$ 2,602,555	$ 2,563,606	$ (38,949)
Carryforward from fund balance	3,080,176	3,909,772	829,596
Total	**$ 5,682,731**	**$ 6,473,378**	**$ 790,647**
Expenditures			
Annual			
Personnel Services and Mandatory Fringes	**$ 1,262,265**	**$ 942,365**	**$ 319,900**
Communications			
Open Enrollment Communications	353,561	286,449	67,112
Operations Communications	156,754	136,483	20,271
Well-Being Communications	175,750	12,363	163,387
Other Communications	90,332	78,078	12,254
Total Communications	**$ 776,397**	**$ 513,373**	**$ 263,024**
Well-Being	337,500	56,916	280,584
Initiatives to Reduce Health Care Costs	282,500	277,445	5,055
Board Transcription Services/SFGOV	18,206	2,907	15,299
Contingency for Unforeseen Issues			-
Total Annual Expenditures	**$ 2,676,868**	**$ 1,793,006**	**$ 883,862**
One-Time			
Communications			
Open-Enrollment Communications	$ 192,400	$ 29,800	$ 162,600
Operations Communications	1,506,532	302,023	1,204,509
Other Communications	181,660	65,185	116,475
COVID-19 Communications		7,767	(7,767)
Total Communications	**$ 1,880,592**	**$ 404,774**	**$ 1,483,584**
Well-Being	100,697	2,220	98,477
Initiatives to Reduce Health Care Costs	234,147		234,147
Total One-Time Expenditures	**$ 2,215,436**	**$ 406,994**	**$ 1,808,442**
Grand Total Expenditures	**$ 4,892,304**	**$ 2,200,001**	**$ 2,692,303**
Balance	**$ 790,427**	**$ 4,273,377**	**$ 3,482,950**

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

GENERAL FUND ADMINISTRATION BUDGET
As of June 30, 2020

	ANNUAL				
	Original Budget	Revised Budget	Non-COVID-19 Actuals	COVID-19 Actuals	Total Actual
REVENUES					
Non-Operating Revenue	624,637	624,637	404,089		404,089
Work Order Recovery	11,454,136	11,454,136	11,408,222		11,408,222
Other Revenue	9,131	9,131	0		0
General Fund Carryforward		325,045	325,045		325,045
TOTAL REVENUES	12,087,904	12,412,949	12,137,356	0	12,137,356
EXPENDITURES					
Personnel Services	5,432,981	5,310,981	4,999,814	309,193	5,309,006
Mandatory Fringe Benefits	2,662,009	2,618,009	2,446,815	138,941	2,585,757
Non-personnel Services	1,804,258	2,148,506	1,533,504	273,618	1,807,122
Materials & Supplies	45,130	55,035	26,907	11,454	38,360
Services of Other Departments	2,143,526	2,280,419	1,933,274	0	1,933,274
					0
TOTAL EXPENDITURES	12,087,904	12,412,949	10,940,314	733,205	11,673,520
REVENUE LESS EXPENDITURES	0	(0)	1,197,042	(733,205)	463,836

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

MEMORANDUM

DATE: June 11, 2020

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

FROM: Abbie Yant
SFHSS Executive Director

RE: Black-Out Notice Extension through June 2021

This memorandum shall notify the Health Service Board ("Board") of the Blackout Period in connection with the San Francisco Health Service System ("SFHSS") competitive bid process for the medical plans and the Rates and Benefits process for the 2022 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 and also 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 commenced on February 13, 2020 and is extended through the competitive bid process for the medical plans (June – December 2020) and the Rates and Benefits cycle for plan year 2022 and therefore is expected to end in July 2021 after the Board of Supervisors final approval.

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

Memorandum

DATE: September 10, 2020

TO: Dr. Stephen Follansbee, President and Members of the Health Service Board

FROM: Larry Loo, MPH Chief Financial Officer
Anne Thompson, MPH VP Aon Consulting

RE: Update on Implementation of the Audit Policy & Plan –
Highlight on Mental Health Parity

This memo is an update on the implementation of the Audit Policy and Audit Plan and a summary of the first completed audit. SFHSS reviewed the Audit Policy and 2020 Plan with the Health Service Board's Governance Committee at the February 25, 2020 meeting. A schedule of audits that would require Third Party resources such as those from Aon Consulting were identified and prioritized. That schedule titled Appendix B was reviewed at the SFHSS meeting and the audits listed below were prioritized to perform first.

Audit Description (Vendor)	**Audit Category**	**Status**
Mental Health Parity (UnitedHealthcare)	Operational and Fiduciary	Completed
Medical – High Cost Claims (Blue Shield of California)	Fiduciary	Phase 3 Completed
Medical – High Cost Claims (Kaiser Permanente)	Fiduciary	Phase 2 Completed
HIPAA Privacy	Operational and Fiduciary	Determined Not Needed
HIPAA Security	Operational and Fiduciary	Needs Assessment in Process
Pharmacy Fraud Waste &Abuse (Blue Shield of California and UnitedHealthcare)	Fiduciary	Phase 1 Completed

The first of the scheduled audits has been concluded and the results were shared with the executive management of SFHSS. The results of the Mental Health Parity Audit are summarized below.

Mental Health Parity and Addiction Equity Act Testing

Executive Summary:
Employer group health plans are required to annually analyze their benefits to ensure compliance with Mental Health Parity laws. Benefits to be offered on new or renewing plans are tested for compliance on financial (claims costs) and administrative (coverage documents) basis. Insured plans (Kaiser and Blue Shield) perform compliance testing on renewals filed with state regulatory agencies. The Self-Funded City Plan requires this audit annually. This current year audit performed by Aon Consulting showed compliance with Mental Health Parity laws and no benefit changes were required.

Background:
The Mental Health Parity and Addiction Equity Act (MHPEA) of 2008 was enacted as part of federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

For the UnitedHealthcare PPO plan, as a self-insured plan, SFHSS (plan sponsor) is responsible for ensuring that the plan is in compliance with MHPEA. Fully insured health plans, such as the SFHSS Kaiser Permanente HMO and Blue Shield of California HMOs demonstrate compliance with MHPEA annually with the DMHC or CDI.

Summary:
The Mental Health Parity Act of 1996 (MHPA) provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.

MHPAEA preserves the MHPA protections and adds significant new protections, such as extending the parity requirements to substance use disorders. Although the law requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated with respect to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does NOT require large group health plans or health insurance issuers to cover Mental Health/Substance Use Disorder (MH/SUD) benefits. The law's requirements apply only to large group health plans and health insurance issuers that choose to include MH/SUD benefits in their benefit packages. However, the Affordable Care Act builds on MHPAEA and requires coverage of mental health and substance use disorder services as one of ten EHB categories in non-grandfathered individual and small group plans.

Audit Process and Results:
SFHSS engaged Aon Consulting to perform he MHPAE testing on the UnitedHealthcare PPO plan. Aon experts worked with publicly available plan documents and engaged with UHC to review the plan under the MHPAE requirements.

Upon completion there were no significant findings. Upon review of plan document materials there was one clarification added regarding the application of visit limits for physical therapy, speech therapy, and occupational therapy only applying to those services that are part of rehabilitative care services. This was not a change in the current benefit or administration of the benefit, but rather a clarification of the current benefit.

San Francisco Health Service System

Federal Mental Health Parity—2019 Plan Design Compliance Review

September 3, 2020

Prepared by Aon
Health Solutions

Empower Results®

Table of Contents

- **Executive Summary**
- **Overview of Compliance Testing Requirements**
- **Plan Design Compliance Review**
- **Next Steps to be Considered**

Executive Summary

- This document summarizes the results of Aon's mental health parity compliance plan design review of San Francisco Health Service System's (SFHSS) medical plan options
- Conclusions represent Aon's best estimate of the plan's compliance, taking into account plan descriptions provided in the *2019 Benefits Summary* provided by UnitedHealthcare (UHC)
- The UHC plans have consistent coinsurance within the office visit benefit design, which appears to be in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and no further testing is necessary
- **Treatment limits were identified for rehabilitative therapies (physical, speech, and occupational), home health, and skilled nursing facilities; however, annual visit limits for mental health and substance use disorders are not applied. Treatment limits appear compliant with mental health parity**
  - All other treatment limits (skilled nursing facility, home health care, chiropractic care, pulmonary rehabilitation, cardiac rehabilitation, cardiac rehabilitation, post-cochlear implant aural therapy, hearing aides, and infertility treatment) pose a low risk of noncompliance but should be discussed with the health plans for their provider practice experience and claim submission practices

Executive Summary

- Emergency Department services have a consistent in- and out-of-network cost share applied within each plan, which appears to be in compliance with MHPAEA and no further testing is necessary
- Parity was not specifically reviewed for SFHSS's pharmacy benefit plan design
  - Plans satisfy parity requirements for pharmacy benefits as long as different tiers are based on reasonable factors (e.g., cost, efficacy, generic vs. brand) and without regard to condition for which drug is prescribed
- Non-quantitative treatment limits could be not be assessed from the descriptions provided

Aon does not engage in the practice of law, and the consulting advice we provide is not (and is not intended as) legal advice. We recommend that SFHSS discuss our assumptions, conclusions, and methodologies with its legal, tax, and other advisors before making any decisions based on these results.

Overview of QTL Compliance Testing Requirements

- The federal MHPAEA of 2008 regulations state that plans may not apply financial requirements (deductibles, copays) or treatment limitations (frequency, duration) to mental health or substance use disorder (MH / SUD) benefits that are more restrictive than the predominant benefit applied to substantially all medical / surgical benefits in the same classification
- Must determine compliance within each of six benefit classifications below and two sub-classifications (in-network and out-of-network):
  - Inpatient
  - Outpatient
  - Office visits
  - Emergency care
  - Prescription drugs
  - All other outpatient items and services (e.g., laboratory, radiology, outpatient surgery, durable medical equipment (DME), home health, hospice, hearing)

Overview of Compliance Testing Requirements

Substantially All:

- A requirement or limitation applies to substantially all if it applies to at least two-thirds of the benefits in that classification
  - If a type or level of financial requirement or treatment limitation does not apply to at least two-thirds of the medical / surgical benefits in a classification, then it cannot be applied to mental MH / SUD benefits in that classification
    - Type—copays, coinsurance
    - Level—magnitude of the requirement or limitation (e.g., dollar or percentage amount)
  - Determination is based upon the dollar amount of all plan payments for medical / surgical benefits in the classification expected to be paid under the plan for the plan year
  - If a single level applies to at least two-thirds of medical / surgical benefits in a classification, then it is also the predominant level and the analysis is complete

Predominant Benefit:

- If a financial requirement applies to at least two-thirds but has multiple levels and no single level applies to at least two-thirds, then determination of the predominant benefit level is required
- The predominant benefit level is the level that applies to more than half of the medical / surgical benefits (based on plan costs) in that classification

MHPAEA Overview

Example—Visit Limits

- Plan cannot impose a visit limit on a MH/SUD benefit unless visit limits apply with respect to substantially all medical/surgical benefits in the same category/classification (e.g., outpatient/ in-network)
  - If substantially all benefits used to treat a medical/surgical condition in that category/classification include visit limits, then number of visit limits applied to MH/SUD benefits cannot be more restrictive than the predominant level (i.e., the number of visit limits) that applies to medical/surgical benefit
  - If the predominant level of visit limits for medical/surgical benefits in that category is 20, then the plan cannot impose visit limits of less than 20 for mental health benefits in that same category/ classification
- Analysis applies to all benefits in the category/classification (e.g., outpatient/in-network) and not just any one specific benefit
  - Irrelevant whether limit for any specific benefit applies similarly to medical/surgical and MH/SUD (e.g., applying visit limit for OT regardless of whether OT is used to treat medical/surgical or MH/SUD may not comply)
  - Plan must look at all benefits in outpatient/in-network category/classification where OT falls and not just that specific benefit

MHPAEA Overview

Example—Visit Limits (continued)

- Difficult to meet substantially all test with respect to quantitative treatment limits like visit limits under these requirements
  - Financial requirements may be easier to meet

Plan Design Compliance Review and Testing

Process Overview

- **Goal**—Determine if the financial requirements (deductibles, copays, coinsurance) and treatment limitations (frequency, duration) for MH / SUD benefits are not more restrictive than the predominant benefit applied to substantially all medical / surgical benefits
- **Step 1**—Review plan design by combination of benefits (or option) and benefit classification and sub-classification to determine if compliance testing is necessary
  - Findings presented in this report
- **Step 2**—Request plan cost data from plan administrator(s)/data warehouse
  - Completed, no additional testing required
- **Step 3**—Conduct compliance testing calculations by benefit classification
- **Step 4**—Determine compliance status of each benefit classification and report to employer

Outpatient—Office Visits

Service	In-Network	Out-of-Network
Office Visit—PCP	85% after deductible	50% after deductible
Office Visit—Specialist	85% after deductible	50% after deductible
Urgent Care	85% after deductible	50% after deductible
Chiropractor Services $1,000 Annual Limit	85% after deductible	50% after deductible
Outpatient Mental / Behavioral Health and Substance Abuse	85% after deductible	50% after deductible
Rehab Physical / Occupational Therapy Total Visit Limit = 60 Individual Limits: Speech Therapy = 60 Visits Pulmonary Rehab = 20 Visits Cardiac Rehab = 36 Visits Post-Cochlear Implant Aural Therapy = 30 Visits	85% after deductible	50% after deductible

Annual limits are a combination of in-and out-of-network visits

Outpatient—Other Services

Service	In-Network	Out-of-Network
Laboratory / X-Ray	85% after deductible	50% after deductible
Advanced Diagnostics (MRI / PET / CAT)	85% after deductible	50% after deductible
Outpatient Surgery	85% after deductible	50% after deductible
Home Health Annual Limit = 120 Visits	85% after deductible	50% after deductible
DME	85% after deductible	50% after deductible
Hospice	85% after deductible	50% after deductible
PHP / IOP	85% after deductible	50% after deductible
Hearing Aid ($2,500 per impaired ear every three years)	85% after deductible	50% after deductible

Annual limits are a combination of in-and out-of-network visits

Inpatient—Hospital

Service	In-Network	Out-of-Network
Inpatient Hospital	85% after deductible	50% after deductible
Skilled Nursing Annual Limit = 120 Days	85% after deductible	50% after deductible
Residential Care	85% after deductible	50% after deductible

Annual limits are a combination of in-and out-of-network visits

Emergency Room

Service	In-Network	Out-of-Network
Emergency Room	85% after deductible	85% after deductible

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

MEMORANDUM

DATE: September 4, 2020

TO: Dr. Stephen Follansbee, President of the Health Service Board

FROM: Abbie Yant, Executive Director of San Francisco Health Service System

RE: Health Service Board Email Account Tracking Policy

Health Service Board Email Account

The Health Service Board ("Board") currently has a public-facing email account that allows members to email the account to ask questions or leave comments regarding Board presentations, San Francisco Health Service System ("SFHSS") benefits, and SFHSS policy matters. The email address can be found on the SFHSS website. If a member emails this address, an automatic response is sent back to the member acknowledging receipt of the email.

The Health Service Board Secretary reviews the email account daily. The emails are also reviewed by the Executive Management staff as needed to ensure that the member's need is routed and assigned to the appropriate SFHSS department and that specific staff is assigned to address the member's needs. In some cases, SFHSS staff will escalate the email to the service provider or vendor staff for reconciliation. The resolution and outcome of each email vary based on each member's concerns or questions. Many of the emails include information protected under the Health Insurance Portability and Accountability Act; others that are policy-specific inquiries are promptly forwarded to the Board.

The last 12 months of emails demonstrate several categories of inquiries:

- Member Services Experience (General Information, Feedback)
- Benefits Inquiry (Open Enrollment, Eligibility/Enrollment, Payments, Provider Information)
- Policy Questions (Rates & Benefits, Plan/Provider changes)
- Board meeting questions (time of the meeting, how to give public comment, agenda)

Currently, policy inquiry emails are sent directly to the Commissioners on their preferred email accounts (some personal and some are city accounts.) Personal accounts are not managed within the City Network or by DT and are therefore not secured to protect our member's personal information.

Recommendations:

1. A monthly Board Email Outcome Report will be compiled to share a high-level overview of all the emails that have been received with the Board. The purpose of this report is to share the outcomes of the email inquiries and requests based on the type of emails received. Ongoing email discussions may likely occur between SFHSS staff to resolve member needs and the Board Secretary will enter the action/resolution from SFHSS to maintain the current status of Member resolution. A template report is attached below. A review and analysis of the

previously received email are underway. Concurrent reports beginning this month, September emails are in development.

2. Ongoing categorization and catalog: Over the next 6 months emails will be tracked and categorized so that member operational needs (Members Services, Benefits questions, and Board meeting inquiries) are directed to SFHSS staff and policy questions are directed to the Board.

3. Going forward, Board Commissioners will use their assigned sfgov.org email for all Board business. Board business is public record and the best practice is to separate public and private email use. This practice will ensure security for both our members and the Board Commissioners. The transition from personal to sfgov.org emails will be complete by November 1, 2020. The Board secretary will arrange individual consultations for Board Members to assist with this transition.

Health Service Board Email Outcome Report September 2019		
Member Need	**Monthly Total**	**Action/Resolution**

If there are any questions or comments on this process, please forward all comments directly to the Board Secretary, holly.lopez@sfgov.org.

LEGISLATIVE UPDATE SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
COVID-19 RELATED				
Federal	Tax Credit	HR 8083 Establish a Temporary Tax Credit for Maintaining Retirement Benefits during the COVID-19 pandemic	Introduced August 21, 2020 and referred to the House Committee on Ways and Means	A summary is in progress.
Federal	Treatment	S 4469 COVID-19 Treatment Coverage Act	Introduced August 6, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions	A bill to ensure coverage of a COVID-19 vaccine and treatment.
Federal	Economic Recovery	S 4320 Coronavirus Response Additional Supplemental Appropriations Act, 2020	Introduced July 27, 2020 and referred to the Senate Committee on Appropriations	A summary is in progress.
Federal	Economic Recovery	HR 6800 Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act	Last Action July 23, 2020 - Committee on Small Business and Entrepreneurship. Hearings held.	This bill responds to the COVID-19 outbreak and its impact on the economy, public health, state and local governments, individuals, and businesses. Among other things, the bill provides FY2020 emergency supplemental appropriations to federal agencies; provides payments and other assistance to state, and local governments; expands paid sick days, family and medical leave, provides funding and establishes requirements for COVID-19 testing and contact tracing; eliminates cost-sharing for COVID-19 treatments.
Federal	Tax Credit	S 4214 Payroll Tax Credit for certain expenses associated with protecting employees from COVID-19	Introduced July 20, 2020 and referred to the Senate Committee on Finance	This bill allows employers a 50% payroll tax credit for the cost of qualified employee protection expenses and qualified workplace reconfiguration expenses paid in a calendar quarter. The bill defines qualified employee protection expenses as the cost of testing employees for COVID-19 (i.e., coronavirus disease 2019), equipment to protect employees from COVID-19, and cleaning products or services for preventing the spread of COVID-19; and qualified workplace reconfiguration expenses as amounts paid to design and reconfigure retail space, work areas, break areas, or other employee or customer areas for the primary purpose of preventing the spread of COVID-19 and such design and reconfiguration is completed pursuant to a plan in place before March 13, 2020, and completed before January 1, 2021.
COST OF DRUGS				
Federal	Cost of Insulin Drugs	HR 7722 Matt's Act to Limit the Price of Insulin Drugs	Introduced July 22, 2020 and referred to the House Committee on Energy and Commerce and the House Committee on Education and Labor	A bill to limit the price of insulin drugs accessible for participants, beneficiaries, and enrollees enrolled in group or individual health insurance coverage and group health plans and for uninsured individuals who have diabetes, and for other purposes.
BENEFIT DESIGN & ENROLLMENT OPTIONS				
Federal	Telehealth	HR 8156 Extend Certain Provisions Relating to Telehealth Services	Introduced September 1, 2020 and referred to the House Committee on Ways and Means; Committee on Energy and Commerce	A summary is in progress.
State	Mental Health and Substance Abuse	SB 855 Health Coverage: Mental Health and Substance Abuse Disorders	Amended in assembly August 24, 2020. Introduced January 14, 2020.	This bill would revise and recast provisions set forth in the Knox-Keene Health Care Service Plan Act and California Mental Health Parity Act. This bill would instead require a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. The bill would prohibit a health care service plan or disability insurer from limiting benefits or coverage for mental health and substance use disorders to short-term or acute treatment. The bill would revise the covered benefits to include basic health care services, as defined, intermediate services, and prescription drugs.

LEGISLATIVE UPDATE SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
Federal	Mental Health and Substance Use Disorders	HR 8060 Require Parity in the Coverage of Mental Health and Substance Use Disorder Services	Introduced August 14, 2020 and referred to the House Committee on Committee on Energy and Commerce; Ways and Means; Education and Labor	This bill would require parity in the coverage of mental health and substance use disorder services provided to enrollees in private insurance plans, whether such services are provided in-person or through telehealth.
Federal	Limitations on HSA	HR 8032 A bill to amend the Internal Revenue Code of 1986	Introduced August 14, 2020 and referred to the House Committee on Ways and Means and the Judiciary	This bill would amend the Internal Revenue Code of 1986 to eliminate limitations on contributions to health savings accounts.
Federal	Flexible Spending	HR 7997 One-Time Distribution of Flexible Spending	Introduced August 11, 2020 and referred to the House Committee on Ways and Means	This bill would allow individuals to mitigate the financial impact of COVID-19 by taking a one-time distribution of flexible spending arrangement funds in certain plan years, and for other purposes.
Federal	Pre-Existing Conditions	S 4506 Pre-Existing Conditions Protection	Introduced August 6, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions	This bill would ensure coverage of pre-existing conditions under private health insurance, and for other purposes.
Federal	Dietary Supplement Products	S 4463 A bill to amend the Internal Revenue Code of 1986	Introduced August 6, 2020 and referred to the Senate Committee on Finance	This bill would amend the Internal Revenue Code of 1986 to include certain over-the-counter dietary supplement products as qualified medical expenses.
Federal	COBRA Continuation Coverage	HR 7942 Extend COBRA Continuation Coverage	Introduced August 4, 2020 and referred to the House Committee on Ways and Means	This bill would provide the option to extend COBRA continuation coverage through the last day of the 1-year period succeeding the COVID-19 emergency period, and for other purposes.
Federal	Flexible Spending	S 4371 Fair FSAs Act of 2020	Introduced July 30, 2020 and referred to the Senate Committee on Finance	This bill would amend the Internal Revenue Code of 1986 to require employers to cash out the flexible spending accounts of employees who separate from employment, and for other purposes.
Federal	Dependent Care FSA	S 4372 Dependent Care Expense Relief Act of 2020	Introduced July 30, 2020 and referred to the Senate Committee on Finance	This bill would provide for unused benefits in a dependent care FSA to be carried over from 2020 to 2021, to provide for benefits to be accessed after termination of employment, and for other purposes.
Federal	Savings to HSA, MSA and FSA Plans	HR 7825 PEEPS Act	Introduced July 29, 2020 and referred to the House Committee on Ways and Means	This bill would amend the Internal Revenue Code of 1986 to create increased opportunities for savings to HSA, MSA and FSA plans, to mitigate the financial strain on families caused by COVID-19, to provide for child nutrition, and for other purposes.
Federal	Limitations on HSA Plans	S 4367 Health Savings Accounts For All Act of 2020	Introduced July 29, 2020 and referred to the Senate Committee on Finance	A bill to amend the Internal Revenue Code of 1986 to eliminate limitations on contributions to health savings accounts.
Federal	Benefits for Lung Cancer Screenings	S 4355 Katherine's Lung Cancer Early Detection and Survival Act of 2020	Introduced July 29, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions.	A bill to amend title XXVII of the Public Health Service Act to require group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for lung cancer screenings for certain individuals without the imposition of cost sharing.
Federal	Behavioral Health and Well-Being	S 4349 Dr. Lorna Breen Health Care Provider Protection Act	Introduced July 29, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions.	A bill to address behavioral health and well-being among health care professionals.
Federal	Continuous Health Coverage	S 4329 Continuous Health Coverage for Workers Act	Introduced July 27, 2020 and referred to the Senate Committee on Finance	This bill would provide premium assistance for COBRA continuation coverage, church plan continuation coverage, and furloughed continuation coverage for individuals and their families.

LEGISLATIVE UPDATE SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
Federal	Dependent Care FSA	HR 7666 Family Savings Flexibility Act	Introduced July 16, 2020 and referred to the House Committee on Ways and Means	This bill (1) increases to $2,750 the maximum amount of unused benefits or contributions remaining in a health flexible or dependent care spending arrangement that may be carried over from the 2020 to the 2021 plan year, (2) increases the maximum contribution amount for health savings accounts, and (3) increases the exclusion from employee gross income of employer-paid dependent care assistance.
Federal	Behavioral Health	HR 7539 - Strengthening Behavioral Health Parity Act	July 15, 2020 - Ordered to be Reported (Amended) by Voice Vote, House Education and Labor Committee	A summary is in progress.
AFFORDABLE CARE ACT				
Federal	Health Care Cost and Coverage	S 4521 A bill to amend the Patient Protection and Affordable Care Act	Introduced on August 11, 2020 and referred to the Senate Committee on Finance	A bill to amend the Patient Protection and Affordable Care Act to reduce health care costs and expand health care coverage to more Americans.
RULE MAKING				
Federal	Department of Health and Human Services, Centers for CMS Issued Interim Final Rule	CMS Issues Interim Final Rule on Risk Adjustment and MLR Reporting and Rebate Requirements	The final rule is effective September 2, 2020. Comments are due November 2, 2020.	The Centers for Medicare & Medicaid Services (CMS) issued an interim final rule clarifying several requirements related to risk adjustment and Medical Loss Ratio (MLR) reporting and rebate requirements for health insurance issuers in the individual and small group markets electing to provide temporary premium reductions associated with the COVID-19 public health emergency. The interim final rule specifies that: For the purposes of 2020 benefit year risk adjustment data submissions, issuers of risk adjustment covered plans that provide temporary premium reductions must report the adjusted plan premiums that reflect actual premiums billed to enrollees for any temporary premium credits provided. Consistent with the reporting of the actual premium amounts billed to enrollees for 2020 benefit year risk adjustment data submissions, HHS's calculation of risk adjustment payment and charges for the 2020 benefit year under the state payment transfer formula will be calculated using the statewide average premium that includes the lower premiums billed by issuer offering these temporary premium reductions. For the purposes of MLR reporting and rebates, the rule clarifies that issuers that elect to provide temporary premium reductions must report as earned premium the actual, lower premium billed to enrollees for any temporary premium credits provided for the applicable months of 2020 coverage.
State	Health Care System Consolidation	SB 977 Health Care System Consolidation: Attorney General approval and enforcement	Amended in Assembly August 24, 2020. Introduced February 11, 2020	Tihs bill will require health care systems, private equity groups, hedge funds, and academic medical centers to obtain advance approval by the California Attorney General for substantially all acquisitions or change of control transactions with health care facilities and providers.The stated purpose of the bill is to prevent anticompetitive health care consolidation in California. If enacted into law, the law will apply to transactions entered into on or after January 1, 2021.

LEGISLATIVE UPDATE SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
Federal	Department of Health and Human Services, Centers for CMS Announced Temporary Policy	Temporary Policy on 2020 Premium Credits Associated with the COVID-19 Public Health Emergency	Temporary Policy was announced on August 4, 2020	The Centers for Medicare & Medicaid Services (CMS) announced it is exercising discretion to adopt a temporary policy of relaxed enforcement to allow health insurance issuers in the individual and small group markets to temporarily offer premium credits for 2020 coverage to support continuity of coverage for individuals, families and small employers who may struggle to pay premiums because of illness or loss of incomes or revenue resulting from the COVID-19 public health emergency. Issuers generally are not permitted under federal law and regulations to reduce premiums that are otherwise due. In light of the urgent need to help individuals and small employers experiencing economic hardship maintain continuous coverage through the COVID-19 public health emergency, CMS will adopt a policy of relaxed enforcement with respect to 45 CFR 147.102, 155.200(f)(4), 155.400(e) and (g), 155.706(b)(6)(1)(A), 156.80(d), 156.210(a), and 156.286(a)(2)–(4) to allow issuers, on a temporary basis, to offer premium credits for 2020 coverage. CMS intends to clarify the medical loss ratio (MLR) and risk adjustment reporting requirements in future rulemaking to ensure that issuers may accurately report premium amounts actually billed for months in 2020 for which issuers provided these credits.
Federal	Department of Health and Human Services, Centers for CMS Announced Temporary Period of Relaxed Enforcement	Temporary Period of Relaxed Enforcement for Submitting the 2019 MLR Annual Reporting Form and Issuing MLR Rebates in Response to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency	Temporary Period of Relaxed Enforcement was announced on August 4, 2020	The Centers for Medicare & Medicaid Services (CMS) announced it is exercising discretion to adopt temporary policies of relaxed enforcement in connection with submitting the 2019 medical loss ratio (MLR) annual reporting form and issuing MLR rebates in response to the COVID-19 public health emergency. CMS is providing this additional flexibility to permit issuers to prepay to enrollees a portion or all of the estimated MLR rebate for the 2019 MLR reporting year to support continuity of coverage for enrollees who may struggle to pay premiums because of illness or loss of income resulting from the COVID-19 public health emergency. CMS is also extending the deadline by which it will accept 2019 MLR Annual Reporting Forms. Under the Affordable Care Act, insurers that cover individuals and small businesses must spend at least 80% of their revenue on health-care costs or send rebates to their enrollees. Large-market insurers with more enrollees must spend at least 85% of their revenue on health costs. The MLR requirements are applicable to health insurance issuers in the individual, small group, and large group markets, including issuers of grandfathered health plan coverage and “grandmothered” (also known as “transitional”) plans subject to the CMS non-enforcement policy. The law requires insurers to submit to CMS their annual medical loss ratio report by July 31. Insurers that choose to provide rebates in the form of a premium credit must apply the rebate to the first month’s premium that’s due on or after Sept. 30. CMS said it won’t take enforcement action against insurers that choose to prepay all or part of its rebate in the form of a premium earlier than Sept. 30. It also won’t take enforcement action against insurers that submit their annual reporting form by Aug. 17.

LEGISLATIVE UPDATE SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
LEGISLATIVE WATCH LIST				
RACIAL EQUITY				
Federal	Federal Holiday	HR 7232 Juneteenth National Independence Act	Introduced June 18, 2020 and referred to the House Committee on Oversight and Reform. No action	A bill to amend title 5, United States Code, to establish Juneteenth Independence Day as a Federal holiday, and for other purposes.
COVID-19 RELATED				
Federal	Tax Credit	HR 7615 Payroll Tax Credit for certain expenses associated with protecting employees from COVID-19	Introduced July 16, 2020 and referred to the House Committee on Ways and Means. No action since then.	This bill allows employers a payroll tax credit for 50% of the sum of qualified employee protection expenses, qualified workplace reconfiguration expenses, and qualified workplace technology expenses paid for each calendar quarter. The bill defines qualified employee protection expenses as the cost of testing employees for COVID-19 (i.e., coronavirus disease 2019), equipment to protect employees from COVID-19, and cleaning products or services for preventing the spread of COVID-19; qualified workplace reconfiguration expenses as amounts paid to design and reconfigure retail space, work areas, break areas, or other employee or customer areas for the primary purpose of preventing the spread of COVID-19, and such design and reconfiguration is completed pursuant to a plan in place before March 13, 2020, and completed before January 1, 2021; and qualified workplace technology expenses as amounts paid for technology systems that employees or customers use for the primary purpose of preventing the spread of COVID-19 and limiting physical contact, and is acquired after March 12, 2020, and placed in service before January 1, 2021.
Federal	Tax Credit	HR 7658 Payroll Tax Credit for certain costs of providing employees with testing for COVID-19	Introduced July 16, 2020 and referred to the House Committee on Ways and Means. No action since then.	A summary is in progress.
Federal	Testing	S 4198 Affordable Coronavirus Testing Act	Introduced July 2, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions. No action since then.	This bill requires health insurance plans to cover through 2021 without cost sharing COVID-19 (i.e., coronavirus disease 2019) serology testing, which looks for the presence of antibodies made in response to an infection. This coverage requirement also applies to federal health care programs including Medicare, Medicaid, the Children's Health Insurance Program, veterans and military personnel health benefits, and federal employee health benefits. Additionally, the bill requires the Department of Health and Human Services to reimburse, through the Public Health and Social Services Emergency Fund, health care providers for the cost of providing diagnosis and treatment for COVID-19 to individuals without health insurance.
Federal	Benefits Enrollment	S 3991 Coronavirus 2019 Special Enrollment Period Act	Introduced June 17, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions. No action since then.	A bill to establish a special enrollment period, beginning July 1, 2020, and ending October 1, 2020, for health plans offered on the Exchanges, in response to the public health emergency related to the coronavirus 2019.
Federal	Emergency Medical Supplies	S 3921 Emergency Medical Supplies Procurement Act	Introduced June 9, 2020 and referred to the Senate Committee on Homeland Security and Governmental Affairs. No action since then.	A bill to require the Federal Government to provide critical health care resources in response to the COVID-19 pandemic.
Federal	Economic Relief and Security	HR 748 Coronavirus Aid, Relief and Economic Security (CARES) Act, also known as "Phase 3"	Became Public Law on March 27, 2020	This bill provides $2 trillion in response to the COVID-19 outbreak and its impact on the economy, public health, state and local governments, individuals, and businesses. Provides $100 billion specifically to “eligible health care providers” for healthcare related expenses or lost revenues attributable to the COVID-19 pandemic. The funding is to address both the economic harm across the entire healthcare system due to cancelation or postponement of elective procedures and to address the financial impact on providers incurring additional expenses caring for COVID-19 patients.

LEGISLATIVE UPDATE SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
Federal	Economic Response	HR 6201 Families First Coronavirus Response Act, also known as "Phase 2"	Became Public Law on March 18, 2020	This bill provides $104 billion in paid sick leave, tax credits, and free COVID-19 testing; expanding food assistance and unemployment benefits; and increasing Medicaid funding.
Federal	Economic Preparedness	HR 6074 Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, also known as "Phase 1"	Became Public Law on March 6, 2020	This bill provides $8.3 billion in emergency funding for federal agencies to respond to the coronavirus outbreak. It funds programs that address issues such as developing, manufacturing, and procuring vaccines and other medical supplies.
SURPRISE MEDICAL BILLING				
Federal	Surprise Medical Billing	HR 5800 Ban Surprise Billing Act	February 2, 2020 Ordered to be Reported (Amended) by the Yeas and Nays: 32 - 13, House Oversight and Reform Committee	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. No action since then.	A summary is in progress.
Federal	Medicare	S 3238 Preventive Home Visit Act	Introduced January 28, 2020 and referred to the House Committee on Finance. No action since then.	This bill expands Medicare coverage to include biennial preventive home visits, in which a qualified professional conducts a risk assessment of an individual's home and provides appropriate referrals for interventions or modifications to improve physical activity, fall prevention, and nutrition.
COST OF DRUGS				
Federal	Cost of Prescription Drugs	S 3384 Lowering Prescription Drug Pricing for America's Seniors and Families Act of 2020	Introduced March 3, 2020 and referred to the House Committee on Finance. No action since then.	A bill to allow for negotiation of prices for certain covered Medicare part D drugs, to allow for importation by individuals of prescription drugs from Canada, to preserve access to affordable generics and biosimilars, to increase the use of real-time benefit tools to lower beneficiary costs, to establish a manufacturer discount program, and for other purposes.
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. No action since then.	The bill would limit amend the Federal Food, Drug, and Cosmetic Act with respect to limitations on exclusive approval or licensure of orphan drugs.
BENEFIT DESIGN & ENROLLMENT OPTIONS				
Federal	Paid Sick Leave	HR 7538 Essential Workforce Parity Act	Introduced July 9, 2020 and referred to the House Committee on Education and Labor, the Committees on House Administration, Oversight and Reform, and the Judiciary. No action since then.	This bill would amend the Families First Coronavirus Response Act to provide paid sick leave for health care providers and emergency responders, and for other purposes.
Federal	Surprise Medical Bills	S 4185 End Surprise Medical Bills for Air Ambulances Act of 2020	Introduced July 2, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions. No action since then.	This bill would establish an independent dispute resolution process for surprise air ambulance bills, and for other purposes.

LEGISLATIVE UPDATE SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
Federal	Telehealth	S 4039 TELEHEALTH HSA Act of 202	Introduced June 23, 2020 and referred to the Senate Committee on Finance. No action since then.	This bill makes permanent the preferred treatment of telehealth and other remote care services for purposes of health savings accounts.
Federal	Group or Individual Health Insurance Coverage	HR 7267 Patients Before Profits Act of 2020	Introduced June 18, 2020 and referred to the House Committee on Energy and Commerce; Ways and Means; Education and Labor. No action since then.	This bill prohibits private health insurance plans from (1) reducing reimbursement rates to health care providers, or (2) terminating a contract with a health care provider in any area where there is a federally-declared public health emergency. The bill does not limit such actions if they are based on fraud, abuse, or concern about the quality of the provider or if the provider is on the exclusion list from federal health programs that is maintained by the Department of Health and Human Services.
Federal	Dependent Care FSA	S 3972 - COVID-19 Dependent Care Flexible Spending Arrangement Rollover Act of 2020	Introduced June 17, 2020 and referred to the Senate Committee on Finance. No action since then.	This bill directs the Department of the Treasury to issue regulations or other guidance that permit the unused balance as of the end of plan year 2020 of any dependent care flexible spending arrangement to be rolled over to plan year 2021.
Federal	Telehealth	S 3988 Enhancing Preparedness through Telehealth Act	Introduced June 17, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions. No action since then.	A summary is in progress.
Federal	Mental Health and Substance Abuse	S 3792 Tele-Mental Health Improvement Act	Introduced May 21, 2020 and referred to the House Committee on Health, Education, Labor and Pensions. No action since then.	This bill requires private health insurance plans that cover in-person mental health or substance use disorder services to cover such services on equal terms via telehealth (i.e., information technology used to aid treatment and diagnosis at a physical distance) during the COVID-19 (i.e., coronavirus disease 2019) public health emergency. Specifically, this bill requires, among other things, plans to cover such telehealth services at the same rate as in-person services, exclude charges for facility fees, and provide information about how to access such services.
Federal	Treatment for Infertility	HR 2803 Access to Infertility Treatment and Care Act	Introduced May 16, 2020 and referred to the Subcommittee on Health June 11. 2020. No action since then.	A summary is in progress.
Federal	Treatment for Infertility	S 1461 Access to Infertility Treatment and Care Act	Introduced May 14, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions. No action since then.	A summary is in progress.
Federal	Continued Coverage for Pre-Existing Conditions	S 3383 Continuing Coverage for Preexisting Conditions Act of 2020	Introduced March 3, 2020 and referred to the Senate Committee on Health, Education, Labor and Pensions. No action since then.	This bill would ensure that preexisting condition exclusions with respect to enrollment in health insurance coverage and group health plans continue to be prohibited; this bill is related to the Continued Coverage for Pre-existing Conditions Act of 2019.
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. No action since then.	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.
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 action since then.	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 SEPTEMBER 10, 2020				
	Subject	Legislation Title	Activity	Comment
TRANSPARENCY				
Federal	Price Transparency	S 4106 Health Care PRICE Transparency Act	Introduced on June 30, 2020 and referred to the Senate Committee on Health, Education, Labor, and Pensions. No action since then.	A bill to amend the Public Health Service Act to provide for hospital and insurer price transparency.
Federal	Improving Awareness of Health Coverage Options	HR 6130 Improving Awareness of Health Coverage Options Act	Introduced on March 9, 2020, referred to the House Committee on Education and Labor. No action since then.	This bill will require the Secretary of Labor to update the model COBRA continuation coverage general notice and the model COBRA continuation coverage election notice, and for other purposes.
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.	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.	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.
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.	The Supreme Court 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.