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

February 13, 2020

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

FROM: Abbie Yant, RN, MA Executive Director SFHSS

RE: February 2020 Board Report

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

HSB 2020 Election
2020 Health Service Board Elections (slides attached) The Health Service Board election will take place during the month of May 2020. The Department of Elections (DOE) is conducting this election. The Board Secretary is collaborating with the City Attorney's office and the DOE. The 2020 election will include one member elected by the active and retired members of the HSS for the term from June 2020- May 2025. The official election practices will begin January 10, 2020, when the nomination forms are available for all SFHSS members to pick up from our offices or download from our website. Completed nomination forms are due back to the SFHSS offices no later than February 14, 2020, at 4:00 pm. Once this piece of the election process is complete, the confirmed nominees will be contacted directly.

We are looking forward to having a very busy and fruitful election over the coming months.

SFHSS has a designated email address for all election-related questions, HSB.Elections@sfgov.org. This email address allows our members to contact us at any time if they have any questions about the nomination process, the voting process, or any general questions that may arise during this election season. The Board Secretary will manage communications for the election, and coordinate with the DOE. The Operations Team is also aware of this communications plan, so if people call or walk into the office for election needs, they will be directed to the Board Secretary.

Sutter Antitrust Case Update
On February 25, 2020, a motion for preliminary approval of the settlement is scheduled to be filed following the agreement to settle on October 16, 2019, in the lawsuit against Sutter Health System regarding alleged consolidation practices. As the impact of the settlement becomes clear, SFHSS will inform the Health Service Board.

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BSC Insurance Cards
During the January 2020 Health Service Board meeting, Commissioner Lim spoke to an issue where members not enrolled in Blue Shield were receiving Blue Shield ID cards. The Enterprise Systems & Analytics team has researched the issue thoroughly and is working closely with the Blue Shield account team, who have identified and corrected the impacted members. As is often the case in complex systems, several solutions are required, which will reduce these errors, and as they are being implemented, staff in identifying and correcting errors as they occur.

SFHSS Post Open Enrollment 2019 Survey Report Out
At the January Health Service Board Meeting, Chief Operating Officer Mitchell Griggs presented information about a premier 2019 Open Enrollment survey aimed at gauging customer effort and satisfaction. The survey debuted in November after the completion of the Open Enrollment period and yielded nearly 1K responses from active and retired members. Questions surfaced from the Board related to SFHSS' intention to benchmark their preliminary scores against industry standards. The Customer Effort Score (CES), Customer Satisfaction Score (CSAT), and Network Promoter Score (NPS) are nationally recognized as evidenced-based measurement tools that are applicable across disciplines, including those that are healthcare-related. As such, what is considered top-tier, mid-range, and low-end scores for each metric does not vary by discipline.

SFHSS is using this development period to collect baseline data for all three scores, which currently reflect Open Enrollment Member Services interactions and Self-Service eBenefits experiences specifically. SFHSS' priority is taking opportunities to gauge customer effort and satisfaction year-round as a part of the new communications and engagement plan, including meeting with internal staff to discuss results and making any needed adjustment to workflow or survey questions. Once a year-round baseline has been developed and tested, considerations for investing in proprietary benchmarking databases can be explored. Access to these benchmarking databases allows SFHSS to understand how our scores compare to other organizations aiming to reach the national standards from both healthcare and non-healthcare related disciplines and to seek new ways of meeting the needs of our members.

References
NPS is developed by (and is a registered trademark of) Fred Reichheld, Bain & Company and Satmetrix
CES is developed by the Customer Contact Council, a division of the Corporate Executive Board (CEB)

Legislative Report Highlights – see attached
California's' request to CMS for the Managed Care Organization (MCO) Tax was denied
The MCO tax originally expired after June 30, 2019. The California Governor's Office requested a federal waiver to have it reinstated retro to July 1, 2019, which was denied by CMS on January 30, 2020. This expired tax helped fund the State's portion of Medicaid costs (where Medicaid is a program funded mostly by the federal government but also partially by states.

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Pamela Levin Retirement

Pamela Levin, SFHSS Chief Financial Officer, has announced her retirement effective 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. She played a significant role in the agency's strategic planning process while also having an impact on the health plan and premium cost containment. SFHSS is deeply appreciative that Pamela will help facilitate a smooth leadership transition, and SFHSS wishes Pamela all the best in her retirement. 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.

Once she is retired, Pamela will begin her next journey in Santa Fe, New Mexico. Pamela looks forward to spending more time volunteering, taking art classes, and being peacefully present with her dog, Shasta, in her new community. Pamela has shared that while she has had little time to reflect on her 38-year career, she is wholeheartedly delighted to be retiring.

EAP/Mental Health

SFHSS is preparing a new general fund budget proposal to expand EAP services due to the increasing demand. In this proposal, we will continue to coordinate with other City Departments that have internal or external EAP services. At this time, led by the SFFD, five 1st responder agencies have prepared a request for proposals (that is not yet public) to go out likely in March for external EAP services. MTA also has contract external EAP services. SFHSS is also working closely with worker's compensation to clarify with them and our EAP regarding the new law that makes Post-Traumatic Stress Disorder "presumed compensable" as a work injury for peace officers and first responders for claims filed on or after 1/1/2020. Workers' compensation claims may be filed under this presumption with for up to five years post-employment. This EAP program expansion will allow us to service more city employees and continue to coordinate and advocate on behalf of our members with our contracted health plans. We will share the proposal with the HSB when it is complete.

Attachments:

ESA Slide
Legislative Report
Black Out Period Memo

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SFHSS DIVISION REPORTS –January 2020

PERSONNEL
Please welcome our newest member of the Enterprise Systems & Analytics Team – Derrick Tsoi who joined SFHSS on February 10th. Derrick adds experience in high-impact health metrics research and will be working on profiling the SFHSS population.

Open Positions:

- 2 1209 Benefits Technician positions appointed – Carmen Zavala started on 1/27/2020, and Kristi Wong began on 2/10/2020
- 1210 Benefits Analyst temporary position appointed – will begin on 2/24/2020
- 0931 Communications Director – offer has been made
- 0923 – Assistant Well Being Manager- recruitment underway

OPERATIONS –

- January saw the lowest inbound call volume since 2016. This indicates that there were fewer errors in delivering Open Enrollment elections.
- 49 members who are in Blue Shield Trio were impacted by their PCPs moving out of Brown &Toland.
    - As if February 1st, 10 members have moved to another plan either through open enrollment or the appeals process for after open enrollment requests.
    - We will continue to honor requests for transfers to a different plan throughout the plan year.

Enterprise Systems & Analytics (ESA) – see project dashboard
In addition to the tracking of major initiatives, in an initial step to developing a population health approach to the health of our members, ESA has completed integrating available race data into the All-Payer Claims Database (APCD). This milestone allows SFHSS to have greater insight into the status of the health and health needs of the SFHSS population.

Modernizing SFHSS Telephone System: Voice Over Internet Protocol (VOIP)
As previously reported, we are close to completing the migration to the VOIP system in partnership with the Department of Technology (DT.) To date:

- DT has finished the installation of the additional power needed for the network upgrade.
- DT has completed the installation of the backup fibre connections for network redundancy.
- In January, DT plans to install the networking equipment for the network upgrade as part of the City's Network Modernization project.
- Once this is complete, DT will move forward with the VOIP cutover, tentatively scheduled for February.

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COMMUNICATIONS

- Produced the Annual Report and Demographic Report.
- Developing Well-Being campaign materials
- Developing mailings to ~1,800 members re: Domestic Partnership Declarations

FINANCE DEPARTMENT

- Finalize FY 2020-21 and FY 2021-22 Budgets for Health Service Board
- Preparing February 21, 2019 General Fund Administration Proposed Budget for submission to Mayor's and Controller's Office
- Preparing for Controller's Office Post Audit Fieldwork 3/3/20

Contracts

- Executed an agreement with Athena Software for Employee Assistance Program (EAP) case management software.
- Executed the first amendment to agreement with Communities in Collaboration for member and stakeholder engagement.
- Completed request for proposal (RFP) for the 2020 Well-being campaign and EAP solutions.
- Selected YMCA of San Francisco for 2020 Change, Intervention, and Diabetes Prevention Program (DPP) for Members.

Well-Being – January 2020

- Launched Live, Feel, Be Better in 2020 with offering 18 onsite advanced health screenings and 3 healthy weight programs across 18 locations.
- 30 onsite activities, of which 60% were seminars.
- 448 Visits to the Catherine Dodd Wellness Center, of which 77% represents group exercise participation.
- Stress management and Healthy Habits seminars were offered with an average participation of 12 individuals per seminar.

EAP – YTD 2019

- 56% of individuals that seek counseling are Kaiser members and 36%, are BlueShield members.
- 92% of individual clients utilizing EAP are being seen for work-related, psychological, or family/marital/relationship concerns/issues.
- 36% increase in the number of organizational consultations provided.
- 145% increase in the critical incident response from the EAP team.

Enterprise Systems & Analytics Report

February 12, 2020

Project	Status	Key Accomplishments
Cybersecurity / Disaster Preparedness		• Microsoft Management console deployed to all servers • Remediate all systems in response to major vulnerability in Windows which was identified by the NSA and considered critical • 4 radios were procured for emergency communications
eBenefits		• Budget requested to support continued expansion of self-service • Currently on hold pending PeopleSoft Upgrade. Next step is to complete UAT of new-hire, new-retiree and qualifying event workflows. Expect new environments available for testing in April.
VOIP telephony upgrade		• Installation of additional required power has been completed • Installation of backup fibre connections for network redundancy has been completed • VOIP cutover anticipated for February. • Currently pending installation of network equipment
Payment Gateway: Member facing payments		• UAT complete. Payment portal goes live 2/7/20. The first members to be able to pay balances will be those with delinquencies • Continued development with phased rollouts will occur
Enterprise Content Management System (ECM) Business Insights / scanner licenses		• Business Insights license procured. Implementation scheduled for Q1
1095 Regulatory filing		• 1095s printed and distributed to all recipients by 1/31/20

 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

LEGISLATIVE UPDATE FEBRUARY 13, 2020

Recent Developments and Legislation

	Subject	Legislation Title	Activity	Comment
State	California Managed Care Organization (MCO) tax		The final FY 2019-20 budget included intent language to continue the tax. Legislation was passed in September. On September 30, 2019 the CA Department of Health and Human Services requested a federal Waiver for the MCO tax.	CMS will not approve the waiver.
Federal	Breast Cancer Diagnosis	S 3216 Access to Breast Cancer Diagnosis	Introduced January 16, 2020. Read twice 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 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.
Federal	Access to Primary and Behavioral Healthcare	H. R. 5575 Primary and Behavioral Health Care Access Act of 2020	Introduced January 10, 2020. Referred to the House Committee on Energy and Commerce, and in addition to the House Committees on Education and Labor, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.	A bill to amend the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to require group health plans and health insurance issuers offering group or individual health insurance coverage to provide for 3 primary care visits and 3 behavioral health care visits without application of any cost-sharing requirement.
Federal	Breast Feeding Accommodations	H. R. 5592 PUMP for Nursing Mothers Act	Introduced January 13, 2020. Referred to the House Committee on Education and Labor.	A bill to amend the Fair Labor Standards Act of 1938 to expand access to breastfeeding accommodations in the workplace, and for other purposes.
Federal	Cost of Prescription Drugs	S. 3166 Prescription Drug Affordability and Access Act	Introduced January 8, 2020, Read twice and referred to the Senate Committee on Health, Education, Labor, and Pensions.	The bill will lower the cost of drugs for all Americans.

Subject	Legislation Title	Activity	Comment	Subject
Federal	Protection for pre-existing conditions	H. R. 5479 To protect Americans with pre-existing conditions	Introduced December 18, 2019 and referred to the House Committee on Energy and Commerce No action since December 18, 2019.	The bill states that "No American shall be denied health insurance due to pre-existing conditions".
Federal	Cost of drugs	H. R. 3 Elijah E. Cummings Lower Drug Costs Now Act	Introduced September 19, 2019. Amended by the House Committee on Energy and December 12, 2019 and referred to the House Committee on the House Committee on Energy and Commerce, House Committee on Ways and Means and House Committee on Education and Labor. Passed by House on December 12, 2019. Received in Senate December 16, 2019.	The bill requires CMS to negotiate prices for certain drugs (current law prohibits the CMS from doing so). Specifically, the CMS must negotiate maximum prices for (1) insulin products; and (2) at least 25 single source, brand-name drugs that do not have generic competition and that are among the 125 drugs that account for the greatest national spending or the 125 drugs that account for the greatest spending under the Medicare prescription drug benefit.. The bill also makes a series of additional changes to Medicare prescription drug coverage and pricing. Among other things, the bill (1) requires drug manufacturers to issue rebates to the CMS for covered drugs that cost $100 or more and for which the average manufacturer price increases faster than inflation; and (2) reduces the annual out-of-pocket spending threshold, and eliminates beneficiary cost-sharing above this threshold, under the Medicare prescription drug benefit.

Rule Making

	Subject	Legislation Title	Activity	Comments
Federal	Department of Health and Human Services, Centers for CMS Proposed Rule Change	Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; etc.	Filed on July 29, 2019 and was published on August 9, 2019. The comment period closes on September 27, 2019. Final rule issued November 12, 2019 with a comment period which has been extended to January 29, 2020. The final rule adopted policies that will continue the advancement of certified EHR technology (CEHRT) utilization, further reduce burden, and increase interoperability and patient access to their health information.	This rule may impact the Medicare rates for 2021 due to the proposed revisions to the Medicare hospital outpatient prospective payment system and the Medicare ambulatory surgical center payment system for CY 2020. In addition, CMS is proposing to establish requirements for all hospitals in the US for making hospital standard charges available to the public and establish a process and requirements for prior authorization for certain covered outpatient department services.
Federal	Department of Health and Human Services, Centers for CMS Proposed Rule Change	Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements.	Proposed rule was issued on July 18, 2019 and comments are due by September 9, 2019. Final rule issued November 8, 2019 with a comment close date of December 30, 2019. This final rule with comment period is effective January 1, 2020	This rule would update the home health prospective payment system (HH PPS) payment rates and wage index for CY 2020; implement the Patient-Driven Groupings Model (PDGM), a revised case-mix adjustment methodology, for home health services beginning on or after January 1, 2020, implement a change in the unit of payment from 60-day episodes of care to 30-day periods of care, and proposes a 30-day payment amount for CY 2020. Additionally, this proposed rule modifies the payment regulations pertaining to the content of the home health plan of care; allow physical therapy assistants to furnish maintenance therapy; and change the split percentage payment approach under the HH PPS. This may impact the development of the Kaiser and UHC 2021 Medicare plan rates.

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

	Subject	Legislation Title	Activity	Comments
Federal	Department of Health and Human Services, Office of Inspector	Medicare and State Healthcare Programs, Fraud and Abuse, Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements	Proposed rule was issued on October 17, 2019 and comments are due on December 31, 2019. The rule is still in the proposed rule stage.	The bill will remove potential barriers caused by four key healthcare laws and associated regulations that impact more effective coordination and management of patient care and delivery of value-based care that improves quality or care, health outcomes, and efficiency. The four key healthcare laws and associated regulations: (i) The physician self-referral law, (ii) the Federal anti-kickback statute, (iii) the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[9] and (iv) rules under 42 CFR part 2 related to substance use disorder treatment.
Federal	Internal Revenue Service, Employee Benefits Security Administration, Health and Human Services Department Proposed Rule	Proposed Rule to require groups health plans to disclose cost sharing information	An Executive Order by President Trump was issued June 24, 2019 and was published in the Federal Register on June 27, 2019. The rule was filed on November 27, 2019 with a January 14, 2020 deadline for comments. The rule is still in the proposed rule stage. All components of the rule would be applicable for plan years (or in the individual market policy years) beginning on or after 1 year after the finalization of the rule, except for the MLR provision, which would be applicable beginning with the 2020 MLR reporting year	The rule requires group health plans to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee (or his or her authorized representative), including an estimate of such individual's cost-sharing liability for covered items or services furnished by a provider. Plans and issuers are to make such information available on an internet website and, if requested, through non-internet means, thereby allowing a participant, beneficiary, or enrollee (or his or her authorized representative) to obtain an estimate and understanding of the individual's out-of-pocket expenses and effectively shop for items and services. The rules also require plans and issuers to disclose in-network provider negotiated rates, and historical out-of-network allowed amounts through files posted on an internet website. The HHS proposes amendments to its medical loss ratio program rules to allow issuers offering group health insurance coverage to receive credit in their medical loss ratio calculations for savings they share with enrollees that result from the enrollee's shopping for, and receiving care from, lower-cost, higher-value providers.

Affordable Care Act

	Subject	Background	Activity	Comments
Court Case – US Court of Appeals for the Fifth Circuit	Texas v Azar (United States Affordable Care Act) Appeal decision of lower court that ruled the ACA unconstitutional due to the unconstitutionality of the individual mandate and inability to sever the mandate from the ACA.	In December 2018, a Texas District Court struck down the ACA in its entirety, finding that the 2017 Tax Cuts and Jobs Act, which reduced the penalty associated with the individual mandate to zero, renders the mandate unconstitutional, and invalidates the mandate as unconstitutional thus invalidates the entire ACA.	On July 9, 2019 the US Court of Appeals for the Fifth Circuit heard oral arguments on the District's Court's decision that the individual mandate is unconstitutional and not severable, it would invalidate the ACA and be appealed to the Supreme Court. The Supreme Court has already upheld the ACA as constitutional in NFIB v. Sebelius and King v. Burwell. 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. In the meantime, the parties supporting the ACA have asked the Supreme Court 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.

Legislative Watch List

	Subject	Legislation Title	Activity	Comments
Federal	Transparency of drug rebates	S. 2247 A bill to amend Titles XI and XVIII of the Social Security Act to increase transparency of drug manufacturers discounts and establish requirements relating to pharmacy-negotiated price concessions.	Introduced July 24, 2019 and referred to the Senate Committee on Finance. No action since July 24, 2019.	This bill would require greater transparence of discounts by drug manufactures and establish requirements relating to pharmacy-negotiated price concessions. The details are pending.
Federal	Cost of Insulin	H. R. 5364 End Price Gouging for Insulin Act	Introduced on December 9, 2019, referred to the House Committee on Energy and Commerce and the House Committees on Ways and Means, Armed Services, Veterans' Affairs, Oversight and Reform and Natural Resources , for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.	The bill would require the Secretary of Health and Human Services to establish an annual reference price for insulin products for purposes of Federal health programs.
Federal	Cost of drugs	H. R. 3947 Competition Prescription Act To Lower the cost of prescription drugs, and for other purposes,	Introduced July 24, 2019 and referred to the House Committee on Energy and Commerce, and in addition to the House Committees on Ways and Means, the Judiciary, Armed Services, and Oversight and Reform. August 28, 2019 Referred to the House Subcommittee on the Constitution, Civil Rights, and Civil Liberties. No action since August 28, 2019.	This bill would lower the cost of prescription drugs by removing delays in introducing generic drugs to the market and expanding patients access to those low-cost alternative drugs. By introducing more generic drugs to the market faster and increasing access to them, the free market will encourage competition between generic and brand-name drugs.

	Subject	Legislation Title	Activity	Comments
Federal	Surprise Medical Billing	S. 1895 Lower Health Care Costs Act	Introduced June 19, 2019. Placed on Senate Legislative Calendar under General Orders July 8, 2019	This bill may protect patients from surprise medical billing and reduce payments to some health care providers working in facilities where surprise bills are likely, allow some generic or biosimilar drugs to enter the market earlier, impose new rules for insurers' contracts with pharmacy benefit managers and health care providers, increase access to health, cost, and quality information among patients, providers, and insurers, which would create new administrative responsibilities that increase costs for insurers and pharmacy benefit managers.
Federal	Drug Pricing, Out-of Pocket Maximums, Transparency	S. 2543 Prescription Drug Pricing Reduction Act of 2019 to amend titles XI, XVIII, and XIX of the Social Security Act to lower prescription drug prices in the Medicare and Medicaid programs, to improve transparency related to pharmaceutical prices and transactions, to lower patients' out-of-pocket costs, and to ensure accountability to taxpayers, and for other purposes.	Introduced September 25, 2019 and referred to the Senate Committee on Finance. Senate Report 116-120 was issued on September 25, 2019. No action since September 25, 2019.	The bill may impact the UHC MAPD rates. It changes the Medicare Part D program by the removal of the coverage gap, reducing the true out-of-pocket expense, improving incentives to increase negotiation between prescription drug plans and manufacturers, protecting the program from manufacturer drug price increases, and increasing transparency into pharmacy benefit manager (PBM) practices and manufacturer drug pricing decisions.
Federal	Drug Pricing, We Protect American Investment in Drugs Act" or the "We PAID Act	S. 2387, A bill to establish a process by which reasonable drug prices may be determined, and for other purposes.	Introduced July 31, 2019 and referred to the Senate Committee on Health, Education. Labor and Pensions. No action since July 31, 2019.	This bill may impact all the SFHSS plans. It requires the establishment of a National Academy of Medicine Study to study how best to determine the reasonableness of a drug's manufacturer list price and retail price and develop at least 1 framework for determining the reasonableness of a drug's manufacturer list price and retail price. In addition, the bill establishes a nonprofit corporation to be known as the Drug Affordability and Access Committee to determine a responsible manufacturer list price and retail price for each applicable drug.

	Subject	Legislation Title	Activity	Comments
Federal	Transparency	H. R. 4379, To amend the Patient Protection and Affordable Care Act to require qualified health plans to have in place a process to remove from publicly accessible provider directories of such plans providers that are no longer within the network of such plans, and for other purposes.	Introduced September 18, 2019 and referred to the House Committee on Energy and Commerce. No action since September 18, 2019.	This bill would require Blue Shield and UHC to have a process to remove providers that are no longer within the network of their respective plan. This process is applicable for each provider listed in a publicly accessible provider directory of such plan that does not submit any claims to such plan for at least a six-month period in a calendar year:
Federal	Transparency	H. R. 5121 To amend title XXVII of the Public Health Service Act and chapter 89 of Title 5, United States Code, to require health insurance issuers to maintain a price comparison tool, and for other purposes.	Introduced on November 15, 2019, referred to the House Committee and Commerce and the House Committee on Oversight and Reform for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. No action since November 15, 2019.	The text of the bill is not available; however, it is expected that this will impact the SFHSS Blue Shield and UHC PPO plans.
Federal	Surprise Medical Billing	H. R. 4223, To amend the Employee Retirement Income Security Act of 1974 to protect patients from surprise medical bills.	Introduced August 30, 2019 and referred to House Committee on Education and Labor. On September 10, 2019 the Sponsor issued introductory remarks on measure. No action since September 10, 2019.	This bill would be applicable to the UHC PPO. It required self-insured group health plans to be solely liable for making payments to an emergency services provider for emergency services covered under the plan that are provided to a participant or beneficiary, and such participant or beneficiary shall not be liable to the emergency services provider for any amount for such services other than the applicable copayment, coinsurance, or deductible amount required under the plan for covered emergency services. .

	Subject	Legislation Title	Activity	Comments
Federal	Improving Provider Directories Act	H. R. 4575, a bill to amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require group health plans and health insurance issuers offering group or individual health insurance coverage to establish a process to address inaccurate information listed in publicly accessible provider directories of such plans and issuers, and for other purposes.	Introduce in House September 27, 2019, and referred to the House Energy and Commerce, House Education and Labor, and House Ways and Means Committee. No action since September 27, 2019.	The bill will require plans to establish a process to address inaccurate information listed in any publicly accessible provider directory of such plan or issuer. The process shall include prominently displaying on each publicly accessible provider directory of such plan or issuer contact information, such as an email address, phone number, or website address, that will allow an individual to notify such plan or issuer of any inaccurate information listed with respect to a provider in such directory; investigate whether such information is inaccurate; and in the case that such plan or issuer determines that such information is inaccurate, correct and update such information in such directory; and submit to the State insurance commissioners of the States in which such plan or coverage, as applicable, is offered, and makes publicly available, an annual report on the number of notifications received during the year involved and the corrective actions taken with respect to such notifications.
Federal	Surprise Medical Billing	H. R. 4223, To amend the Employee Retirement Income Security Act of 1974 to protect patients from surprise medical bills.	Introduced August 30, 2019 and referred to House Committee on Education and Labor. On September 10, 2019 the Sponsor issued introductory remarks on measure. No action since September 10, 2019.	This bill would be applicable to the UHC PPO. It required self-insured group health plans to be solely liable for making payments to an emergency services provider for emergency services covered under the plan that are provided to a participant or beneficiary, and such participant or beneficiary shall not be liable to the emergency services provider for any amount for such services other than the applicable copayment, coinsurance, or deductible amount required under the plan for covered emergency services. .

	Subject	Legislation Title	Activity	Comments
Federal	Chronic Condition Copay Elimination Act	H. R. 4457 Chronic Condition Copay Elimination Act	Introduced on September 24, 2019 and referred to the House Committee on Energy and Commerce, House Committees on Education and Labor, House Committee for Ways and Means. No action since September 24, 2019.	The bill may impact SFHSS since it will require group health plans and health insurance issuers offering group or individual health insurance coverage to provide coverage for additional preventive care for individuals with chronic conditions without the imposition of cost sharing requirement, and for other purposes. Chronic Conditions are defined as Heart disease, including congestive heart failure and coronary artery disease, diabetes, osteoporosis and osteopenia, hypertension, asthma, liver disease, bleeding disorders, and depression. The criteria is that the item or service is low-cost, there is medical evidence supporting high-cost efficiency, or a large expected impact, of the item or service in preventing exacerbation of the chronic condition or the development of a secondary condition, there is a strong likelihood, documented by clinical evidence, that the item or service will prevent the exacerbation of the chronic condition or the development of a secondary condition that requires significantly higher-cost treatments.
State	Pharmacy Benefit Management Reporting to the California Department of Managed Health Care (DMHC)	Required by AB 315 passed in 2018	The task force met July 31, 2019, September 12, 2019, October 14, 2019 and December 4, 2019. The DMHC's report to the Legislature based on Task Force recommendations is due February 1, 2020.	The result of the work of the Task Force will increase the transparency of how pharmacy benefit managers operate and determine if PBMs are serving the best interests of the patients, and not just increase the PBM's bottom line.
State	Change of Gender: Updated marriage and birth certification	California SB 741	Senate Committee on Judicial and Senate Committee on Health hearing was scheduled on July 9, 2019 but it was canceled at the request of the author of the legislation. No actions since July 9, 2019.	The SFHSS workload may increase if this bill is passed.
Federal	Healthcare Insurance Tax	S. 80 Jobs and Premium Protection Act	No action since January 10, 2019 when it was referred to the Senate Committee on Finance.	This bill would repeal the annual fee on health insurance providers enacted by the Patient Protection and Affordable Care Act. Tax is still effective in 2020.

	Subject	Legislation Title	Activity	Comments
Federal	Healthcare Insurance Tax	H.R. 2447 Jobs and premium Protection Act	No action since May 1, 2019 when referred to the House Committee on Ways and Means, and in addition to the House Committee on Energy and Commerce.	This bill would repeal the annual fee on health insurance providers enacted by the Patient Protection and Affordable Care Act. Tax is still effective in 2020.
Federal	Drug Rebates	H. R. 1034 Phair Pricing Act of 2019	No action since February 7, 2019 when referred to the House Committee on Energy and Commerce, and in addition to the House Committee on Ways and Means.	This bill would amend title XVIII of the Social Security Act to require pharmacy-negotiated price concessions to be included in negotiated prices at the point-of-sale under Part D of the Medicare program.
State	Out-of-Network Coverage	A B 72 Health care coverage, out-of-network	Introduced in the California Assembly December 18, 2014, Signed by the Governor on Sept 23, 2016. Bill challenged by Association of American Physicians and Surgeons in the U.S. District Court. The motion to dismiss was granted the defendant (DMHC) on June 6, 2019.	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2017, to provide that if an enrollee receives covered services from a contracting health facility, and receives covered services provided by a noncontracting individual health professional, the enrollee would pay the in-network rates.
State	Emergency Hospital Services; Costs	AB 1611, Emergency Hospital Services	No action since referred to the Senate Committee on Health hearing canceled at the request of the author.	This bill would require a health care service plan contract amended, or renewed on or after January 1, 2020, to provide that if an enrollee receives covered emergency services from a noncontracting hospital, with certain exceptions, the enrollee will pay the in-network rates.
Federal	Funding research on clinical effectiveness of medical treatments	HR 3439 Protecting Access To Information for Effective and Necessary Treatment Act" or the "PATIENT Act".	Introduced June 24, 2019 referred to the House Committee on Ways and Means, and to the House Committee on Energy and Commerce. On June 26, 2019, ordered to be reported as a substitute. No action since June 26, 2019.	This bill would extend the Patient-Centered Outcomes Research Trust Fund (PCORI) and the fee. This may increase premiums.

	Subject	Legislation Title	Activity	Comments
Federal	Medical billing practices Hospital's balanced billing	H. R. 3630 No Surprises Act. A bill to amend title XXVII of the Public Health Service Act to protect health care consumers from surprise billing practices, and for other purposes.	Introduced July 9, 2019 and referred to the House Committee on Energy and Commerce and the House Committee on Education, referred on July 10, 2019 to the House Subcommittee on Health. On July 11, 2019 House Subcommittee on Health held consideration and mark-up session and then forwarded to the Full House Committee on Energy and Commerce. No action since July 11. 2019.	This bill would end surprise medical bills (balanced billing) and adds third-party arbitration. The bill addresses the market failure at the heart of surprise billing; appropriately uses notice and consent exceptions; and establishing a minimum insurer payment that would likely avoid increasing health care spending relative to the status quo.
Federal	Lowering Health Care Costs	S 1895 Lower Health Care Costs Act	Introduced June 19, 2019 in Senate, Assigned to Senate Committee on Health, Education, Labor and Pensions on June 26, 2019, Amended as a substitute bill on July 8, 2019, placed on Senate Legislative Calendar under General Orders. No action on amended bill.	This bill would end surprise billing, reduce high cost of prescription drugs, require transparency, fairness and competition in the health care system, fund America's public health infrastructure, and improve health information technology.

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

MEMORANDUM

DATE: February 13, 2020

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

FROM: Abbie Yant
SFHSS Executive Director

RE: Black-Out Notice for 2021 Rates and Benefits

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

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

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

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

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

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