Orange County Association of Health Underwriters

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C.O.I.N.

COUNTY OF ORANGE INSURANCE NEWS

OCAHU
Orange County Association of Health Underwriters

Inside this Edition:

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Thank you for being a part of OCAHU!

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OCAHU
Orange County Association of Health Underwriters

Making a Difference in People's Lives. One Member at a Time.

Our association is a local chapter of the National Association of Health Underwriters (NAHU). The role of OCAHU is to promote and encourage the association of professionals in the health insurance field for the purpose of educating, promoting effective legislation, sharing information and advocating fair business practices among our members, the industry and the general public.

Would you like to be more involved in our industry?

Contact a board member today!

See page 14 for a list of members.

PRESIDENT'S MESSAGE

By: JoAnn Vernon

As my year comes to a close, I would like to thank each of our members, sponsors and our fearless OCAHU board. Many times people forget that we volunteer, yes volunteer. We do it out of love and passion for our industry, and to seek out those we want to be around. I've always said that if you are not going to support the industry that provides for you, then who will? We are very lucky in Orange County to have such strong leaders in our organization that will continue to work and grow our community. We feel pressure legislatively as different bills are introduced that threaten what we do daily. What can't come across in a bill that is introduced is the tireless hours, training and knowledge that goes into making sure we understand the provisions to advise our clients with the best possible information to make informed choices.

At this time, I would like to thank Gail, Juan, Pat, Maggie, David B, Jennifer, David E, Gonzalo, Adriana, Sarah, Briana, MaryAnna, Louis and John. They all work very hard and without them, things wouldn't get done. THANK YOU!

##

CAHU
California Association of Health Underwriters

Are you contributing to CAHU-PAC?

Have a voice in legislation! Consider contributing so your voice can be heard at our state's capitol. CAHU-PAC is working for your best interest and those of your clients.

To start contributing copy the form on page 21 of this issue and mail to CAHU today!

Thanks for your participation!

The STATEment

CAHU's Magazine!

Check out CAHU's bi-monthly online magazine at

https://www.cahu.org/newsroom.

Feature Article:

Employers Retirement Plans and CalSavers Deadline

By: Paul Roberts - Director of Education and Market Development, Word & Brown General Agency

California enacted a new law in 2016 requiring employers that do not already sponsor an employee-retirement plan, to participate in a state-run retirement program called CalSavers. Employers with 5 or more employees (of any type – full time, part time, seasonal) must enroll in the program by June 30, 2022.

Since 2020, all California businesses have been eligible to participate in the CalSavers program; however, the approaching final registration deadline of June 30, 2022, encompasses all employers with five or more employees. Employers with 100 or more employees had a prior registration deadline of September 30, 2020. Employers with 50 or more employees had a prior registration deadline of June 30, 2021. An employer that already sponsors, or begins to sponsor, a traditional retirement plan ahead of the deadline does not have a CalSavers participation requirement.

Additionally, Californians can enroll on their own as individuals if they do not have access to a retirement savings plan through an employer.

The CalSavers program is not intended to be a traditional retirement plan. Instead, it is a state-run program to help employees begin thinking about and saving for retirement. It aims to remove many of the complexities involved in sponsoring a traditional retirement plan, which can be especially challenging for smaller employers due to federal ERISA law.

Most importantly, CalSavers does not make employers ERISA plan fiduciaries. An important caveat is that the employer must not advise its employees on where to invest funds, and the employer can neither encourage nor discourage participation in the program. If an employer does either of these things, then ERISA law would require the employer to become the plan fiduciary, which would bring additional compliance challenges to the employer.

While the program is voluntary for employees, the law requires employers to proactively enroll all employees in the program. Employees must be enrolled in the program by the group size-specific deadline, or within 30 days after date-of-hire for employees hired after the deadline.

When employees are enrolled, they begin a 30-day decision period when they can leave the plan as-is, make changes to the plan (contribution changes, etc.), or opt-out of the program entirely. During this window, employers must work with their payroll providers to begin providing deduction amounts for employees. At the conclusion of the 30-day period, unless changes are made, employees will be enrolled in the program beginning with a 5% payroll deduction.

Employees can customize their enrollments in several ways: change the contribution rate, change investment fund choices, designate beneficiaries, manage personal information, make a withdrawal, or set up additional personal contributions.

Employees can contribute anywhere from 0% to 100% of salary, up to the annual IRS maximum contribution allowance, which is $20,500 in 2022. Employees can make changes to their plans at any time throughout the year, including opting out.

Funds withheld from employees' paychecks are based on gross income, and are withheld on a post-tax basis. The funds go into a Roth IRA; however, employees have the option of re-characterizing the program into a traditional IRA. Regardless of the employee's IRA type, the plan will always belong to the employee. The employee's first $1,000 deduction is put into a traditional money market fund, called the CalSavers Money Market Fund, for thirty days. All subsequent contributions, including earnings in the Money Market Fund, will be re-allocated to a CalSavers Target Retirement Fund, based on the employee's age and anticipated retirement date.

Employers will not incur fees for participating in the program; however, it's important to understand that employers cannot contribute to employees' plans. Doing so would make them the plan's ERISA fiduciary, with complex compliance responsibilities. If an employer wants to make contributions to employees' retirement plans, it can do so via a traditional retirement plan.

CalSavers offers registration and enrollment services to aid employers in compliance and enrollment; information is available by sending an email to clientservices@calsavers.com. More information, including an in-depth FAQ section, is available on the CalSavers website.

Non-compliance penalties for violation of the retirement-program mandate are hefty, and are assessed by the California Franchise Tax Board. Under Government Code Section 100033(b), each eligible employer that, without good cause, fails to allow its eligible employees to participate in CalSavers on or before 90 days after its deadline, will be fined $250 per W-2 employee.

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Legislative Update:

Treasury Department Issues Proposed Regulations to Fix ACA "Family Glitch"

By: David Benson - OCAHU VP Legislation

The following article was posted on the NAHU website

The Biden administration released a proposed rule In April to fix the family glitch. This proposed rule is a result of President Biden's executive order from 2021 calling on the federal agencies to strengthen the ACA. The Department of Treasury is using the proposed rule to revise the definition of "affordability" of employer-sponsored coverage as it applies specifically to family members of the employee. If finalized, this regulation would go into effect on January 1, 2023.

Current regulations define employer-based health insurance as "affordable" if the coverage solely for the employee, not for family members, is affordable – making family members ineligible for a premium tax credit. The interpretation of the ACA that created the family glitch stems from a final rule issued in 2011, in which the IRS cited a 2011 analysis from the Joint Committee on Taxation that interpreted the affordability test to be based on employee-only coverage.

Fixing the family glitch has been a priority of NAHU since its existence was recognized. Studies show that the family glitch has prevented approximately 5 million Americans from receiving premium tax credits (PTCs) for ACA marketplace coverage even though they would normally qualify. The majority of this group – 2.8 million – are children, and nearly half (46 percent) are low-income. If this issue were rectified, millions of Americans would become eligible for PTCs on the ACA exchange.

The proposed rule released last month would amend the affordability test to allow for the family members of workers who are offered affordable self-only coverage but unaffordable family coverage to qualify for PTCs in the exchange. The rule would also refine the minimum-value rule for family coverage as well as clarify the treatment of rebates for purposes of PTC eligibility. It is important to note that the affordability and minimum-value tests would be changed only as they relate to family coverage, not employee-only coverage. The proposed rule would also not impact the affordability test for employees. Employees would still be barred from accessing ACA subsidies if their employer offers affordable employee-only coverage, but their family members would no longer be.

More specifically, an offer of employer-based health coverage would be affordable for family members if the part of the annual premium that an employee had to pay for family coverage were less than 9.5 percent of household income. From there, the marketplace would assess whether the employee has an offer of affordable employee-only coverage, whether the family members have an offer of affordable family coverage, and whether any of those family members have an offer of affordable coverage from another employer. For these calculations, the relevant family members would be those in the employee's tax family, such as a spouse filing jointly or a dependent. Family coverage would be defined as "all employer plans that cover any related individual other than the employee." If an individual were presented coverage from multiple employers, just one of those offers would need to be affordable to prevent access to PTCs. An offer of affordable family coverage from any employer would make family members ineligible for PTCs.

By making these changes through the regulatory process, the administration is potentially opening itself up to several lawsuits. The IRS previously interpreted that it did not have the authority to make the changes that the agency is now proposing. Because of this, legal challenges are likely if the rule is finalized. NAHU will continue to monitor the progress of this proposed regulation and share any relevant news. We will be submitting comments to the administration in the coming weeks with our observations and concerns. To learn more about this proposed rule, read NAHU's Compliance Now blog post and listen to NAHU Podcast - Healthcare Happy Hour.

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YOU AREN'T ALONE YOU HAVE NAHU!

NAHU
National Association of Health Underwriters

As a health insurance and benefits specialist, you face many challenges in your quest to survive and thrive in a changing marketplace:

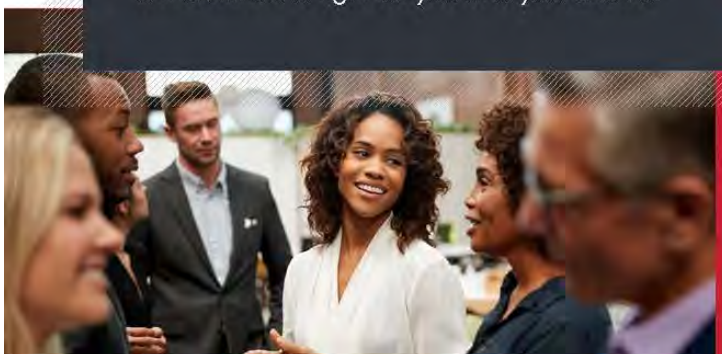
- Staying up to date on important issues that affect your clients and your business.
- Staying compliant.
- Furthering your professional development by staying educated and getting appropriate certifications.
- Networking with your peers and learning best practices.
- Fighting to be treated fairly for the services you provide.

The National Association of Health Underwriters (NAHU) is your solution to all of these challenges, and more.

With what's happening in the world today, more than ever you need to have a resource like NAHU! It's important for you to be a part of a professional association that influences legislation and regulations that will safeguard and enhance your career.

NAHU is the association that has your back and will continue to fight for you and your clients.

Without NAHU, what will you do? Who will help you survive and thrive?



Become a member today at nahu.org/membership!

Not a member? Join us today!

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JOIN OCAHU

Update on Federal "No Surprises Act" Changes to Health Plans

By: Paul Roberts - Director of Education and Market Development, Word & Brown General Agency

The Federal Consolidated Appropriations Act (CAA) of 2021 brings significant changes to the American health care and health insurance industries – as well as many other changes to unrelated sectors. The CAA, which is dually the longest bill by page count and the largest spending bill in American history, specifically targets "transparency" in health care and health insurance.

CAA's "No Surprises Act" requires health plans, health care providers, and health care facilities to make changes to the administration and operation of health plans, in efforts to improve the consumer experience – especially with regards to billing, claims, and benefits.

With its significant and far-reaching changes, the CAA's requirements and implementation dates vary. Some changes have already been implemented, some are forthcoming, some have been delayed, and others are on hold.

Regulators are still working on creating regulations and guidance for some of these changes, all of which are slowly trickling out at varying intervals. Regulations give us more detail about a law's implementation and enforcement details – which are critical for compliance. However, the law does not require regulators to release regulations for laws. For CAA's "No Surprises Act," we are still awaiting guidance and regulations in many areas. In fact, there are some portions of the law that have been implemented, but have not been given any additional detail yet. Regulators are closely observing the facilitation and implementation of these changes, and will continue to release more information as it becomes necessary and available.

For employers with fully insured plans, most changes will be facilitated by the health plan issuer (the carrier). Employers with self-funded plans will need to take measures to ensure changes are made to their plans, including satisfying implementation rules and deadlines.

Regardless of the health plan's funding structure, Federal ERISA law places "fiduciary responsibility" on almost all employer plan sponsors. Ultimately, the plan sponsors' Federal ERISA fiduciary responsibilities require them to ensure their plans meet all obligations – including recent changes – even for those with fully insured plans. This column contains a high-level summary of the latest information, as of April 2022.

Prohibition of Gag Clauses

In order to facilitate transparency in health care and to insert CAA's transparency changes alongside overlapping "Transparency in Coverage" rules of the Affordable Care Act (ACA), health plans/issuers are prohibited from contracting with providers who would prevent/restrict the plan from sharing provider-specific cost details or "quality of care" information to the plan sponsor, participants/beneficiaries, or referring providers.

This provision, which went in effect on December 27, 2020, prevents providers from putting a "gag clause" into their contracts, which would otherwise prevent a plan sponsor from sharing such critical pricing/quality transparency information with interested parties.

The Department of Labor (DOL) will require attestations from plan sponsors for this requirement in the future. However, the attestation provision is on indefinite hold until more details become available from regulators.

Mental Health Parity

The Mental Health Parity & Addiction Equity Act (MHPAEA) of 2008 generally requires health plans to ensure "mental health" and "substance use disorder" benefits are equivalent in structure to their plans' standard "medical and surgical" benefits.

If a plan's mental health benefit comes with (non-numerical) limitations, then those same limitations must also exist for the plan's medical and surgical benefits. MHPAEA calls such limitations "non-qualitative treatment limitations" (NQTLs), which include items that limit the scope or duration of treatment but are not expressed numerically – such as prior-authorization requirements, etc.

CAA requires plans to produce "comparative analyses" of their benefit structures, to analyze mental health and medical/surgical benefits – to ensure the plan is meeting the requirements from the 2008 law. Furthermore, CAA now requires plans to use DOL's MHPAEA Self-Compliance tool. Using the tool previously had generally been a mere recommendation.

This Mental Health Parity item is in effect now, and the DOL is currently conducting audits and requesting information from employer health plans about it. In previous rounds of audits before the CAA was signed into law, the DOL found significant non-compliance among all health plans. The "No Surprises Act" intends to bolster compliance in this area.

Continuity of Care

If a "continuing care patient" is receiving significant care from a provider, and that provider leaves the health plan's network, then that patient may continue to see the (now out-of-network) provider at in-network rates for up to 90 days.

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No Surprises Act Update, cont. from page 8

A "continuing care patient" is a person undergoing treatment for a "serious and complex condition"; a person undergoing institutional or inpatient care; a person scheduled to undergo non-elective surgery; a person who is pregnant and undergoing treatment for the pregnancy; or, a person who is terminally ill and is receiving treatment. Plans must also have a plan in place to notify "continuing care patients" when providers or facilities leave a plan's network. These changes are in effect for health plan years beginning January 1, 2022.

Surprise Billing

The "No Surprises Act" places strict limitations on plans regarding balance billing – which is when a patient receives treatment at an in-network facility by an out-of-network provider, and gets "surprise billed" by the out-of-network provider for the balance of unpaid out-of-network claims. These "No Surprises Act" surprise billing changes generally apply to plans with plan years beginning on/after January 1, 2022.

A health plan may not assess out-of-network charges for patients receiving treatment for emergency care at out-of-network facilities. The CAA assigns a "prudent layperson" standard with regard to determining "emergency" services. Under this standard, if a common "layperson" would assume a condition to be an "emergency" (even if it is not), the surprise billing consumer protections apply. Additionally, providers must generally collect patient consent before sending a stabilized patient to an in-network facility, following an emergency.

Furthermore, a health plan may not "balance bill" in non-emergency circumstances, if that patient seeks care at an in-network facility but is treated by an out-of-network provider, tested by an out-of-network lab, etc. Some out-of-network providers, however, can ask a patient to consent to receiving non-emergency out-of-network services at the in-network facility in advance. However, this does not apply to emergency medicine, anesthesiology, and other services that had previously been common "surprise bill" scenarios.

Lastly, a new model notice has been released by the Centers for Medicare & Medicaid Services (CMS) which plan fiduciaries are required to distribute to participants, detailing these "surprise billing" limitations. Furthermore, plans and insurance issuers must post on a public website and include in each Explanation of Benefit (EOB) information regarding balance billing restrictions, applicable state laws and restrictions on balance billing, and contact information for federal and state agencies that can assist if a patient receives a prohibited "surprise" balance bill.

Provider Network Directories

In efforts to enhance accuracy of information in health care, health plans with plan years effective 1/1/2022 are required by law to keep their provider network directories up to date under strict timeframes. Plans must have an established process in place to verify and update provider directories at least once every 90 days. Furthermore, plans must update their databases within two business days of a provider leaving a network.

Plans must also respond to participants' questions about provider networks (via telephone and electronically) within one business day. They must also have a provider directory listed on a public website, and must include statements about accuracy in printed directories (if applicable). Lastly, if a plan participant is given incorrect information about a provider being "in network" when the provider is not "in network," then the plan must pay benefits at in-network amounts.

ID Card Updates

The CAA requires health plans with plan years beginning on/after January 1, 2022 to list plan deductibles, out-of-pocket limits, and a phone number and website address for consumer assistance on all members' health plan ID cards. (Many health plans issued new ID Cards in late 2021 or early 2022 to begin complying with the law.)

Good-Faith Estimates by Providers to Consumers

The CAA requires health plans (with plan years beginning on/after January 1, 2022) to provide good-faith estimates to inquiring consumers about the cost of care for requested procedures. Providers are required to produce an estimate, including billing and diagnostic codes, for a consumer to analyze with his/her/their health plan to understand cost sharing for the service.

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COIN COMPLIANCE CORNER

What Agents and Your Clients Need to Know!

HIPAA Privacy & Security Enforcement Updates—

By: Dorothy M. Cociu, RHU, REBC, GBA, RPA, LPRT - CAHU VP Communications

There haven't been any recent HIPAA Privacy, Security or HITCH Civil Monetary Penalties or Case Settlements announced by HHS or OCR since our last update, but there has been plenty of activity in Washington on the Regulatory and Judicial front. Besides the confirmation of Ketanji Brown, the first black female confirmed for the US Supreme Court, there is a lot to update you on.

OCR Cybersecurity Newsletter Released; Defending Against Common Cyber-Attacks

On March 17, OCR released its OCR Cybersecurity Newsletter, focusing on defending against common cyber-attacks. According to OCR, throughout 2020 and 2021, hackers have targeted the health care industry seeking unauthorized access to valuable electronic protected health information (ePHI). The number of breaches of unsecured ePHI reported to the U.S Department of Health and Human Service's Office for Civil Rights (OCR) affecting 500 or more individuals due to hacking or IT incidents increased 45% from 2019 to 2020.[i] Further, the number of breaches due to hacking or IT incidents accounted for 66% of all breaches affecting 500 or more individuals reported to OCR in 2020.[ii]

Although some attacks may be sophisticated and exploit previously unknown vulnerabilities (i.e., zero-day attack), most cyber-attacks could be prevented or substantially mitigated if HIPAA covered entities and business associates ("regulated entities") implemented HIPAA Security Rule requirements to address the most common types of attacks, such as phishing emails,[iii] exploitation of known vulnerabilities, and weak authentication protocols. If an attack is successful, the attacker often will encrypt a regulated entity's ePHI to hold it for ransom, or exfiltrate the data for future purposes including identify theft or blackmail. Cyber-attacks are especially critical in the health care sector as attacks on ePHI can disrupt the provision of health care services to patients. This newsletter explores preventative steps regulated entities can take to protect against some of the more common, and often successful, cyber-attack techniques.

OCR's newsletter discussed Phishing incidents, the most common of attack vectors. Phishing is a type of cyber-attack used to trick individuals into divulging sensitive information via electronic communication, such as email, by impersonating a trustworthy source.[iv] A recent report noted that 42% of ransomware attacks in Q2 2021 involved phishing.[v] All regulated entities' workforce members should understand they have an important role in protecting the ePHI their organization holds from cyber-attacks. Part of that role involves being able to detect and take appropriate action if one encounters suspicious email. To ensure workforce members can take appropriate action, regulated entities should train their workforce members to recognize phishing attacks and implement a protocol on what to do when such attacks or suspected attacks occur (e.g., report suspicious emails to appropriate IT personnel).

The HIPAA Security Rule requires regulated entities to implement a security awareness and training program for all workforce members.[vi] A regulated entity's training program should be an ongoing, evolving process and be flexible enough to educate workforce members on new and current cybersecurity threats (e.g., ransomware, phishing) and how to respond. Management personnel should also participate, as senior executives may have greater access to ePHI and are often targeted in phishing email attacks (e.g., whaling[vii]).

Regulated entities should follow up on security training with periodic security reminders. The Security Rule includes an addressable[viii] provision for such reminders.[ix]

The newsletter also discussed Exploiting Known Vulnerabilities, when hackers can penetrate a regulated entity's network and gain access to ePHI by exploiting known vulnerabilities. A known vulnerability is a vulnerability whose existence is publicly known. The National Institute of Standards and Technology (NIST) maintains the National Vulnerability Database (NVD),[xii] which provides information about known vulnerabilities. Exploitable vulnerabilities can exist in many parts of a regulated entity's information technology infrastructure (e.g., server, desktop, and mobile device operating systems; application, database, and web software; router, firewall, and other device firmware). Often, known vulnerabilities can be mitigated by applying vendor patches or upgrading to a newer version. If a patch or upgrade is unavailable, vendors often suggest actions to take to mitigate a newly discovered vulnerability. Such actions could include modifications of configuration files or disabling of affected services. Regulated entities should pay careful attention to cybersecurity alerts describing newly discovered vulnerabilities. These alerts (several sources of which are enumerated below) often include information on mitigation activities and patching.

Although older applications or devices may no longer be supported with patches for new vulnerabilities, regulated entities should still take appropriate action if a newly discovered vulnerability affects an older application or device. Regulated entities should upgrade or replace obsolete, unsupported applications and devices (legacy systems). However, if an obsolete, unsupported system cannot be upgraded or replaced, additional safeguards should be implemented or existing safeguards enhanced to mitigate known vulnerabilities until upgrade or

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replacement can occur (e.g., increase access restrictions, remove or restrict network access, disable unnecessary features or services).[xiii]

Lastly, the newsletter discussed Weak Cybersecurity Practices, when that entity makes itself an attractive soft target. Weak authentication requirements are frequent targets of successful cyber-attacks (over 80% of breaches due to hacking involved compromised or brute-forced credentials).[xxi] Weak password rules and single factor authentication are among the practices that can contribute to successful attacks. Once inside an organization, weak access controls can further contribute to an attacker's ability to compromise systems by accessing privileged accounts, moving to multiple computer systems, deploying malicious software, and exfiltrating sensitive data.

Because this topic never seems to be old, and far too many people and organizations continue to be targeted for cyber breaches, theft and more, I will be covering this topic in the Feature Article of the May-June, 2022 issue of CAHIP's The Statement, so stay tuned.

Public Comments Requested on Recognized Security Practices and Sharing Civil Monetary Penalties and Settlements Under the HTECH Act.

On April 6, 2022, HHS' Office of Civil Rights Released an update stating that they were seeking comments on Recognized Security Practices and Sharing Civil Monetary Penalties and Monetary Settlements Under the HITECH Act.

The U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) released a Request for Information (RFI) seeking input from the public on two requirements of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), as amended in 2021. The growing number of cybersecurity threats are a significant concern driving the need for enhanced safeguards of electronic protected health information (ePHI). This RFI will enable OCR to consider ways to support the healthcare industry's implementation of recognized security practices. The RFI also will help OCR consider ways to share funds collected through enforcement with individuals who are harmed by violations of the HIPAA Rules.

"This request for information has long been anticipated, and we look forward to reviewing the input we receive from the public and regulated industry alike on these important topics," said OCR Director Lisa J. Pino. "I encourage those who have been historically underserved, marginalized, or subject to discrimination or systemic disadvantage to comment on this RFI, so we hear your voice and fully consider your interests in future rulemaking and guidance."

Through the April 6, 2022 RFI, OCR is seeking public comment on the following provisions of law:

- **Recognized Security Practices.** Section 13412 of the HITECH Act requires HHS to take into consideration certain recognized security practices of covered entities (health plans, health care clearinghouses, and most health care providers) and business associates1 when determining potential fines, audit results, or other remedies for resolving potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule pursuant to an investigation, compliance review, or audit. Public Law 116-321 went into effect when it was signed into law on January 5, 2021.

  One of the primary goals of this provision is to encourage covered entities and business associates to do "everything in their power to safeguard patient data."

  The RFI solicits comment on how covered entities and business associates are implementing "recognized security practices," how they anticipate adequately demonstrating that recognized security practices are in place, and any implementation issues they would like OCR to clarify through future guidance or rulemaking.

- **Civil Money Penalty (CMP) and Settlement Sharing.** Section 13410(c)(3) of the HITECH Act requires HHS to establish by regulation a methodology under which an individual harmed by a potential violation of the HIPAA Privacy, Security, and/or Breach Notification Rules may receive a percentage of any CMP or monetary settlement collected with respect to such offense. Section 13140(d)(1) of HITECH requires that OCR base determinations of appropriate penalty amounts on the nature and extent of the violation and the nature and extent of the harm resulting from such violation. The HITECH Act does not define "harm," nor does it provide direction to aid HHS in defining the term.

  The RFI solicits public comment on the types of harms that should be considered in the distribution of CMPs and monetary settlements to harmed individuals, discusses potential methodologies for sharing and distributing monies to harmed individuals, and invites the public to submit alternative methodologies.

OCR encourages comments from all stakeholders, including patients and their families, HIPAA covered entities and their business associates, consumer advocates, health care professional associations, health information management professionals, health information technology vendors, and government entities.

Individuals seeking more information about the RFI or how to provide written or electronic comments to OCR should visit the Federal Register to learn more:

- https://www.federalregister.gov/documents/2022/04/06/2022-07210/considerations-for-implementing-the-health-information-technology-for-economic-and-clinical-health

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CMS Releases Final 2023 Notice of Benefit and Payment Parameters

By: David Benson - OCAHU VP Legislation

The following article was posted on the NAHU website

CMS released the final rule on the 2023 Notice of Benefit Payment Parameters yesterday, maintaining much of what was included in the proposed 2023 NBPP back in January. Overall, the final rule primarily touches on new standards for health plans, marketplaces, as well as agents, brokers and web-brokers.

One major change the NBPP makes is preventing issuers in the individual and group marketplace from applying premium payments made for new coverage to any outstanding debt owed from any previous coverage. It would also prohibit issuers from refusing to effectuate new coverage due to failure to pay outstanding premium debt from the previous year.

To support network adequacy, CMS finalized prospective network-adequacy reviews. The reviews will focus on time and distance as well as appointment waiting times starting in plan year 2024. They will also focus on whether providers offer telehealth options. Beginning for plan year 2023, CMS will evaluate QHPs for compliance with quantitative network-adequacy standards based on time and distance standards. Beginning for plan year 2024, CMS will also evaluate QHPs for compliance with appointment wait time standards. These reviews will occur prospectively during the QHP-certification process. Issuers that are unable to meet the specified standards would be able to submit a justification to explain why they are not meeting the standards, what they are doing to work toward meeting them, and how else they are protecting consumers instead.

Changes that directly impact NAHU members are new standards of conduct for agents, brokers and web-brokers. The first of these changes expands on and codifies the existing requirement that agents, brokers and web-brokers provide correct information to the exchanges (such as the consumer's email address, mailing address, telephone number and household-income projections). The next of these changes prevents agents, brokers and web-brokers from engaging in scripting and other automation of interactions with CMS systems or direct-enrollment pathways unless approved in advance in writing by CMS. The NBPP also ensures that, when helping individuals with eligibility for a SEP, agents, brokers and web-brokers will obtain authorization from the consumer to submit the request for a determination of eligibility for a SEP. The rule also finalizes changes that will prohibit QHP advertising or otherwise providing favored or "preferred placement" in the display of QHPs on web-broker websites based on the compensation an agent, broker or web-broker receives from QHP issuers.

CMS also finalized changes to require issuers in federal and state-based marketplaces to offer standardized plan options at every product network type, at every metal level, and throughout every service area that they offer non-standardized options in 2023 and beyond.

Additionally, the NBPP finalizes changes to scale back pre-enrollment SEP verification to include only the SEP for loss of minimum essential coverage—the SEP type that comprises the majority of all SEP enrollments on the marketplaces on the federal platform—and to clarify that marketplaces maintain the option to verify eligibility for any SEP types and may provide an exception to pre-enrollment SEP verification when verification may cause undue burden (such as during natural disasters or public health emergencies impacting consumers or the marketplace).

The final rule also revises the verification process health insurance exchanges must undertake to determine if individuals are truly qualified to be premium tax credit recipients due to their eligibility status for qualified employer-sponsored coverage. This means that each exchange would have the flexibility to tailor its employer-sponsored plan-verification process based on its assessment of the risk of inappropriate eligibly determinations and the composition of their enrolled population.

Regarding non-discrimination protections, the final NBPP reverts this section to the way it was in the 2020 NBPP. The 2021 NBPP, originally finalized by the Trump administration, removed the definition of "on the basis of sex" from the non-discrimination protections. CMS revealed that it will be releasing an additional proposed rule later this year to make further changes to non-discrimination protections and to promote health equity.

Regarding reporting requirements, CMS also finalized changes to collect and extract through issuers' Enrollee-Level External Data Gathering Environment (EDGE) servers five new data elements including ZIP Code, race, ethnicity, individual coverage Health Reimbursement Arrangement (ICHRA) indicator, and a subsidy indicator as part of the required risk-adjustment data that issuers must make accessible to HHS in states where HHS is operating the risk-adjustment program. Reporting will be voluntary in 2023 and 2024 but mandatory in 2025.

The final major changes the 2023 NBPP makes is concerning prorated premiums and advanced premium tax credits. Under the proposed NBPP, HHS would have prorated premium payments of less than one month in all marketplace types, both federal and state-based. In the final rule released yesterday, this prorating methodology only applies to federally facilitated marketplaces to give state-based exchanges more time to consider how to make changes to possibly align with this change in the future. ##

Compliance Corner, cont. from page 11

Please note that comments must be submitted by June 6, 2022 in order to be considered.

I will update you more in the next issue!

_____

[i] See https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf.

[ii] Id.

[iii] "A technique for attempting to acquire sensitive data, such as bank account numbers, through a fraudulent solicitation in email or on a web site, in which the perpetrator masquerades as a legitimate business or reputable person." See https://csrc.nist.gov/glossary/term/phishing.

[iv] See OCR February 2018 Phishing Cybersecurity Newsletter https://www.hhs.gov/sites/default/files/cybersecurity-newsletter-february-2018.pdf.

[v] See https://www.coveware.com/blog/2021/7/23/q2-ransom-payment-amounts-decline-as-ransomware-becomes-a-national-security-priority.

[vi] See 45 CFR 164.308(a)(5)(i): Standard: Security Awareness and Training.

[vii] "A specific kind of phishing that targets high-ranking members of organizations." See https://csrc.nist.gov/glossary/term/whaling.

[viii] See 45 CFR 164.306(d)(3). Addressable implementation specifications require regulated entities to assess whether an implementation specification is a reasonable and appropriate safeguard in its environment, and if so to implement it. If a particular implementation specification is not reasonable and appropriate, entities must document why, and implement equivalent alternative measures if reasonable and appropriate.

[ix] See 45 CFR 164.308(a)(5)(ii)(A): Implementation Specification: Security Reminders (addressable).

[xii] "The NVD is the U.S. government repository of standards-based vulnerability management data represented using the Security Content Automation Protocol (SCAP)." See https://nvd.nist.gov.

[xiii] See OCR Fall 2021 Cybersecurity Newsletter. https://www.hhs.gov/hipaa/for-professionals/security/guidance/cybersecurity-newsletter-fall-2021/index.html.

[xxi] Verizon. 2020 Data Breach Investigations Report. (2020, p. 19). Retrieved from https://enterprise.verizon.com/resources/reports/2020/2020-data-breach-investigations-report.pdf

##

Employer Retirement Plans, cont. from page 5

If noncompliance extends beyond 90 days, employers can be fined up to an additional $500, for a total of $750 per W-2 employee. Employers can be penalized for missing any step of the process – including not registering employees by the deadline, not adding new-hires to the CalSavers system within 30 days, not submitting contribution amounts, cessation of program facilitation, etc.

Although this mandate is not necessarily related to health insurance, it is one of major importance to California employers. Ensuring your clients are aware of the CalSavers deadlines will help you prove your value to your clients – and aid in your client retention and business growth.

##

No Surprises Act, cont. from page 9

Advanced Explanation of Benefits (EOBs) by Plans to Consumers

When consumers receive "good faith estimates" from providers, health plans will be required to produce "Advanced EOBs" for covered participants/beneficiaries utilizing those estimates – showing how benefits will be paid under the plan, the provider's network status, etc. However, this "Advanced EOB" requirement is currently delayed – pending further regulatory guidance.

Price Comparison Tool

For health plans with plan years effective on/after January 1, 2023, price comparison tools for services must be made available to consumers. Plans must offer guidance via telephone and make an online price comparison tool available, allowing a plan participant to compare the amount of cost sharing he/she/they would be responsible for paying under the plan for a service, from a specific provider. These items closely mirror the ACA's "transparency in coverage" requirements – however, the CAA explicitly requires plans to provide these services via telephone, whereas the ACA does not. More detail from regulators is expected in this area.

Broker Commission Transparency

Health insurance brokers and consultants are required to disclose commission structures on self-created disclosure notices, in advance of a client's selection of services and/or plan renewal. Disclosure is required for agents earning at least $1,000 or more in direct or indirect compensation. You may want to revisit a previous column that details these new Federal Broker Commission Disclosure Requirements.

##

OCAHU Board of Directors and Staff 2021-2022

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Why Get Involved in OCAHU?

- *Learn more about our industry*
- *Become a better consultant to help your clients*
- *Network with professionals in all areas*
- *Be a resource to your colleagues*
- *Make an impact with legislation*

NAHU Professional Development

Are you new to the industry? Do you want to brush up on new concepts? Do you have employees who need training? Do you want to be an expert on industry topics so you can educate your clients? NAHU can help….

NAHU has an Online Learning Institute and offers courses in a variety of areas that can help you be successful. NAHU members receive a discount on enrollment of up 30%. Some of the course work and certificates are listed below, but there are many more options on the website. For more information on courses and enrollment, visit the NAHU website at **http://nahu.org/professional-development/courses**.

- Registered Employee Benefits Consultant (REBC) Designation
- Single-Payer Healthcare Certification
- Account-Based Health Plans Certification
- Benefit Account Manager Certification
- Diversity, Equity and Inclusion in the Modern Workplace
- Health Insurance 101
- Self-Funded Certification
- HIPAA Compliance Training

OCAHU 2021 Annual Report

Income	
Dues	$10,818
Corporate Sponsorships	$32,500
Monthly Meeting Registration	$330
Continuing Education Day	$325
Business Development Summit	$19,575
Senior Summit	$5,000
PAC Contributions	$480
Charitable Events	$40,802
COIN Newsletter Advertisements	$0
Miscellaneous Income	$250
Interest Income	$18
Total Income	***$110,098***
Cost of Sales	
Monthly Meetings	$190
Charitable Contributions	$36,874
Continuing Education Day	$0
Business Development Summit	$12,824
Senior Summit	$0
Total Cost of Sales	***$49,888***
Expenses	
OCAHU Administration / General Chapter Management	$36,158
Membership & Recruitment	$0
Legislative Activities	$8,000
Conferences / Education	$2,786
Total Expenses	***$46,944***

VANGUARD SOCIAL EVENT

May 28, 2022

DES Portuguese Hall - Artesia

A social event with bullfights, a concert, dancing, food and drinks! Join the OC, IE and LA Health Underwriters Chapters for an entertaining evening on Saturday, May 28th.

DES Portuguese Hall
11903 Ashworth Street – Artesia 90701

Gates open @ 5:30 PM | Bullfights @ 6:30 PM
Concert & Dancing @ 9 PM
Food and beverages sold all day.

The main goal of the Artesia DES Hall is to promote Portuguese traditions and heritage through the many diverse activities held year-round. One of the traditions is Portuguese-style bullfighting. This style differs in many aspects from Spanish-style bullfighting, most notably is the fact there is no blood shed as the bull is not killed. With the grace of a dancer and the wiry strength of a jockey, the bullfighters will entertain us with the bull and its ways.

Following the bullfights, there will be a concert and dancing in the outdoor courtyard. Performing in the gazebo the smooth country sounds of **Sheyna Gee and the Boys** from Nashville, TN.

COST TO ATTEND: $40
REGISTRATION LIMITED TO THE FIRST 50 PPL
(Includes: Admission, traditional Portuguese Bifana sandwich, fries and a soft drink.)

CMS Releases 2023 Medicare Advantage and Part D Rate Announcement

By: David Benson - OCAHU VP Legislation

The following article was posted on the NAHU website

On Monday, CMS released the Announcement of 2023 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. In the CY 2023 MA and Part D Advance Notice, CMS solicited comments on a variety of topics, including seeking input on promoting health equity in Medicare Advantage and Part D plans. Overall, an average of 8.5 percent increase to payer revenues is expected in 2023.

The change in star ratings, changes in normalization and the Medicare Advantage risk score trend projections stayed the same between the advanced notice and the final rate. CMS finalized a 0.54 percent boost to Medicare Advantage star ratings, on average.

The agency also finalized changes to the risk-adjustment model for payment to Medicare Advantage organizations for members with end-stage renal disease, noting that the agency will continue to evaluate the ESRD risk-adjustment models, including the commenters' recommendations, and consider whether any refinements to the methodology for the ESRD model calibration may be warranted in future years.

Every year, the agency adjusts its Medicare Advantage coding pattern to account for differences between fee-for-service Medicare and Medicare Advantage. In 2023, CMS raised the coding pattern by just 5.9 percent, the least amount of change allowed. CMS declined to update the Medicare Advantage normalization factor, which aims to keep fee-for-service Medicare risk scores relatively unchanged. Instead, the agency will apply risk scores from 2016 through 2020.

In the CY 2023 Advance Notice, CMS also described agency efforts to advance health equity including: collecting more and improved data on beneficiaries' race, ethnicity and social determinants of health; developing quality measures and methodological enhancements that better measure and strengthen methods of addressing health disparities; and driving value in the Medicare program to make sure that the Medicare dollar is spent effectively and efficiently on programmatic changes that will close health-equity gaps. In this week's Announcement, CMS noted that the agency plans to conduct a thorough review of comments to examine further actions CMS might take, including coordinating across programs that CMS oversees, to reduce barriers to health equity.

##

Follow OCAHU on Social Media!

https://www.facebook.com/OCAHU/

https://www.linkedin.com/groups/4100050/

https://twitter.com/orangecountyahu?lang=en

Women In Business 2022

Bottomless Hope: Brunch and Bubbles

By: Patricia Stiffler, LPRT - Women In Business Chair

Even though our 20th Annual Celebration of Women in Business Charity Luncheon & Fashion Show has been postponed to June 2023, the Committee still wanted to celebrate and support New Hope Grief Support Community this year.

We are happy to announce **BOTTOMLESS HOPE: Brunch & Bubbles**, benefiting New Hope. This smaller scale event will be held on June 10, 2022, from 11 AM to 2 PM at the Lake Forest Community Center.

Our ever-popular Pop-the-Cork fundraiser and our beautiful raffle baskets will be on display and ready for you to win!

Please be sure to register early - space available to the first 150 guests [limit of 5 tickets max per registrant]. When tickets are gone, they…are…gone!

[Due to the overwhelming response of our Charity event in the past, soft holds will not be accepted. Payment must accompany reservation to solidify your 'ticket' to attend].

BROUGHT TO YOU BY

ORANGE COUNTY ASSOCIATION OF HEALTH UNDERWRITERS

BOTTOMLESS HOPE

Brunch&Bubbles

JUN 10

DATE

Friday, June 10, 2022
11 AM to 2 PM

TICKET

COST

$70 per person
(Only 150 tickets available)

LOCATION

Lake Forest
Community Center Courtyard
100 Civic Center Drive, Lake Forest, CA 92630

All proceeds go to support New Hope Grief Support Community

HELPING GRIEVING PEOPLE FIND HOPE AND HEALING — NEW HOPE Grief Support Community

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FOR MORE INFORMATION CALL: 714.441.8951 | WWW.OCAHU.ORG

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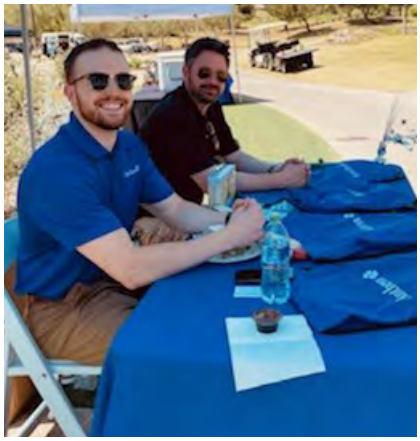
Golf Tournament Photos



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Michael Roberts
(949) 230-2572
michael.s.roberts@anthem.com

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CAHU Podcast Series

Check out CAHU's new Podcast Series at: *http://anchor.fm/cahu* and **https://www.cahu.org/our-issues** or on Spotify! (search CAHU) or at cahu.org. Designed to allow CAHU members to share with their office staffs, employer clients and consumers!

Latest Podcasts:

- How Close Did We Come to Single Payer Healthcare in California?
- Medicare Updates

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NAHU Agency Dues Model 2022

By: Gonzalo Verduzco - OCAHU VP Membership

The National Association of Health Underwriters represents our profession and our clients' interest in affordable access to quality health insurance and related benefits throughout America. Membership enhances our ability to advocate before state and federal decision-makers on the issues that impact our clients and our businesses. The Agency Dues Model 2022 program simplifies dues and payments (one amount per month based on your agency size) and provides full membership (and related benefits) to all of your employees who work on health, dental, vision and related benefits for employers or individuals.

The NAHU Agency Dues Model 2022 is available to agencies of two to 99 that enroll 100% of EAMs. It offers a streamlined billing process with one invoice, one renewal date and one payment each month to cover all your eligible employees.

EAMs in Agency	2-4	5-9	10-15	16-24	25-39	40-50	51-74	75-99
Monthly Cost	$65	$120	$275	$530	$665	$800	$1,100	$1,700

EAMs are producers in your agency who sell employee benefits, individual health insurance, Medicare or other health related products, as well as account managers and compliance professionals who are on staff and work with clients. This would not include those agency employees who work exclusively on life insurance or commercial and/or personal property and casualty insurance. With this fixed agency dues model program, all eligible agency members will receive the benefits available as a member of NAHU.

20% Geographical Adjustment

Local Chapters	All State & Local Chapters
Atlanta, GA	Massachusetts
Lexington, KY	Minnesota
Baton Rouge, LA	Nebraska
Springfield, MO	New York
Dallas, TX	North Carolina
Houston, TX	West Virginia
Lubbock, TX	
San Antonio, TX	
Wichita Falls, TX	

30% Geographical Adjustment

All Local Chapters in the Following States:
California
Connecticut
Florida

Note: Agencies with members in the chapters listed below are subject to an additional fee to support the chapter's advocacy efforts. This adjustment is set on pro-rata basis.

JOIN OCAHU

Enrolling in the Agency Dues Model is easy. The steps are listed below. If you have questions, please contact btretter@nahu.org or (202) 595-7564.

ENROLL IN NAHU'S AGENCY DUES MODEL IN 4 EASY STEPS:

1. Contact Bob Tretter at btretter@nahu.org to get an eligibility form and eligible agency member (EAM) spreadsheet.
2. Complete eligibility form and fill out the spreadsheet listing all current members from your agency as well as new eligible members. Send back to Bob Tretter at btretter@nahu.org.
3. Once confirmed, you will receive an itemized invoice outlining the monthly cost for all your employees for the program. Your itemized invoice will prorate the dues for any current members to sync everyone onto your agency membership.
4. Each EAM you enrolled will receive a welcome email with their NAHU log-in information and a description of all benefits. You may update your agency membership anytime through the agency membership account.

Membership News

We'd like to welcome the newest members of OCAHU!

Sabas Ayona Loya
Ailene Dewar
Linda Madril
David Miller
Ronda Mottl
Jo Nelson
Chelsea Paradiso
John Roberts
Patricia Scoma
Ronald Sellers
Jeff Strong
Eric Terrazas
Terry Tutton

Women's Leadership Summit Photos

California Association of Health Underwriters Political Action Committee
2520 Venture Oaks Way, Ste 150
Sacramento, CA 95833
FPPC # 892177

CAHU PAC CONTRIBUTOR COMMITMENT FORM

LAST NAME FIRST NAME MIDDLE

OCCUPATION (Required for FPPC reporting purposes)

EMPLOYER (if self employed, name of business; Required for FPPC reporting purposes)

WORK ADDRESS (Please provide street address only, no P.O. Boxes) ☐ Check if address for Credit Card

CITY, STATE, ZIP PHONE FAX

HOME ADDRESS (Please provide street address only, no P.O. Boxes) ☐ Check if address for Credit Card

CITY, STATE, ZIP PHONE FAX

CONTACT EMAIL ADDRESS LOCAL CHAPTER

PRECIOUS GEM STONE CONTRIBUTION LEVELS

Levels	Annual	Monthly Minimum	Diamond Levels	Annual	Monthly Minimum
Ruby	$250 - $499	$21/month	One Star	$1,000 - $1,999	$85/month
Emerald	$500 - $719	$42/month	Two Star	$2,000 - $2,999	$170/month
Sapphire	$720 - $999	$60/month	Three Star	$3,000 - $3,999	$250/month
			Four Star	$4,000 - $4,999	$340/month
			Five Star	$5,000 - $6,000	$420/month

NOTE: POLITICAL CONTRIBUTIONS ARE REPORTED TO THE FPPC. YOUR NAME, AS A CONTRIBUTOR, WILL BE A MATTER OF PUBLIC RECORD.

PAYMENT METHOD: (attach check or select method below)

Payment Method	Card or Account #	Exp. Date	Security Code	Monthly Amount	One-Time Contribution
Check Enclosed					$
Visa/MC/Amex				$	$
Auto-checking withdrawal	PLEASE ATTACH A VOIDED CHECK			$	

Bank Draft / Credit Card Authorization: *I (we) hereby authorize the CAHU PAC to initiate debt entries to my (our) checking account and or credit card. Monthly or one-time debits to be made as shown above. Monthly contributions will continue to be drawn until CAHU PAC is notified in writing to cease. I understand that if I should request changes to the amount withdrawn or a cancellation of these charges that it may be 30 days before these changes to become effective.*

Signed: _____ ***Date:*** _____

Please return this PAC Commitment Form to:
Mail: CAHU PAC 2520 Venture Oaks Way, Ste 150, Sacramento CA 95833
FAX: (916) 924-7323 Questions: (800) 322-5934

Revised: 10/2019

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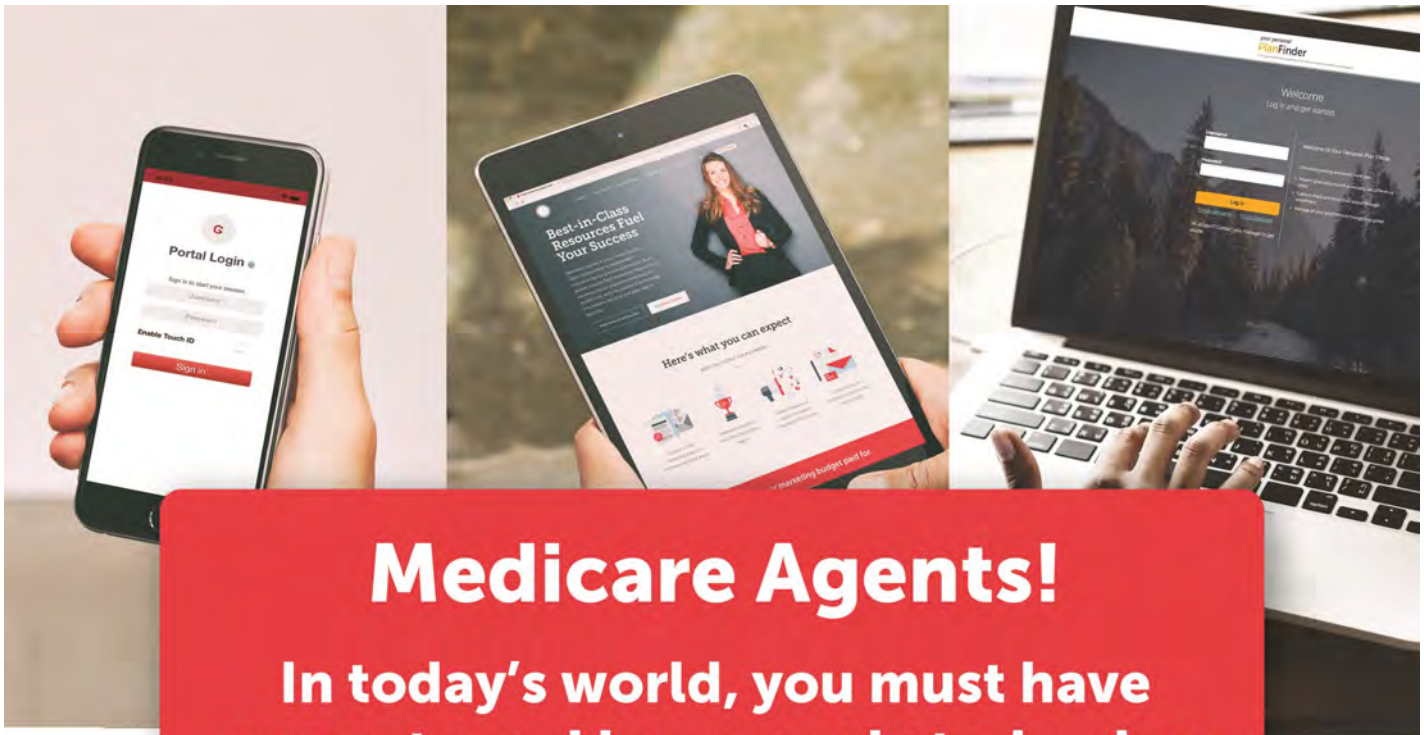

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Please join us at our events!

UPCOMING EVENTS:

May 17, 2022	***Monthly Luncheon Meeting & Member Appreciation, Tustin Ranch Golf Club***
May 28, 2022	***Vanguard Social Event, DES Portuguese Hall - Artesia***
May 17, 2022	***Bottomless Hope: Brunch & Bubbles, Lake Forest Community Center***
June 25 - 28, 2022	***2022 NAHU National Convention, Austin TX***
August 23 - 25, 2022	***10th Annual Senior Summit, Pechanga Resort Casino***
June 2, 2023	***Women In Business, Balboa Bay Resort***

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