Orange County Association of Health Underwriters

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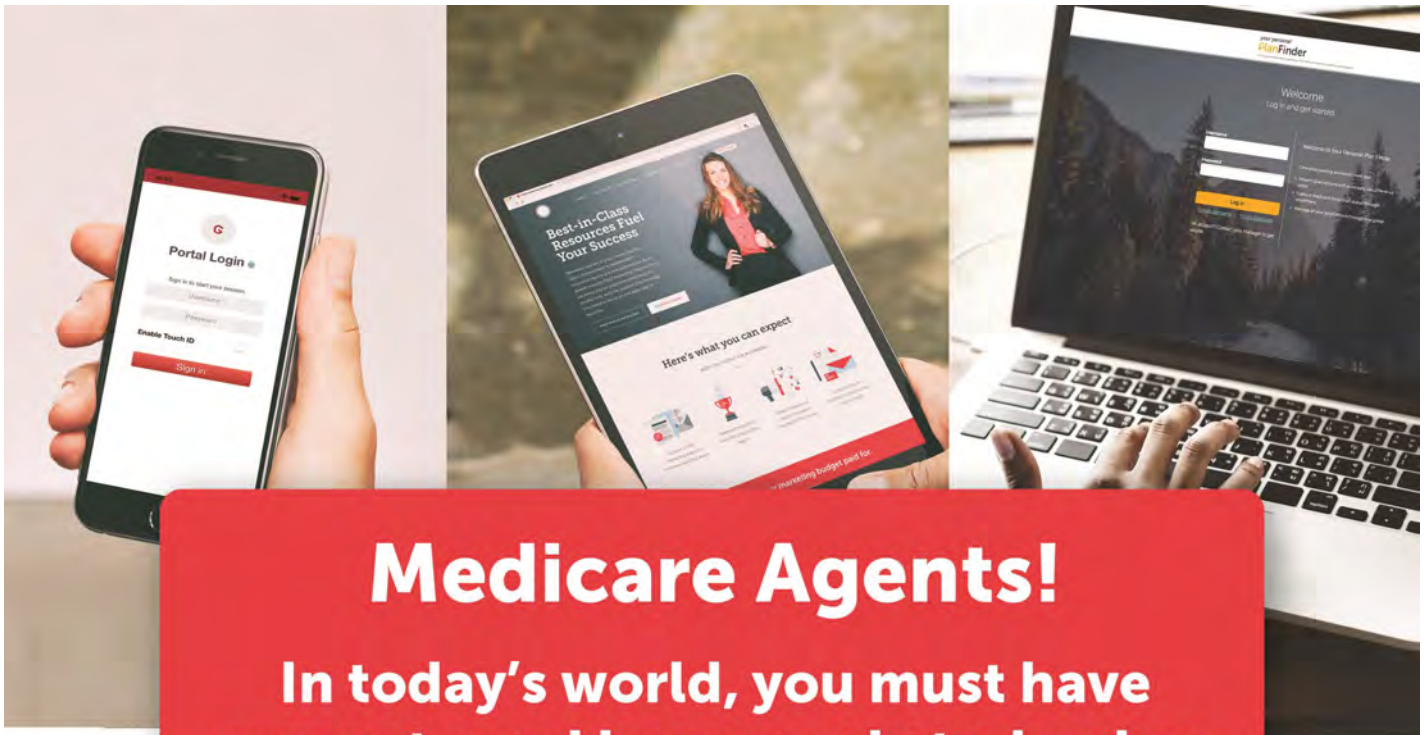
C.O.I.N.

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: Patricia Stiffler, LPRT

I'm baaaaack! Yes, I am back for a second round of the Presidency of OCAHU. OCAHU is one of the most respected Chapters in our association, so I am humbled and honored to lead our Chapter for the 2022-23 term.

Many of us recently returned from the NAHU National Convention in Austin. All the attendees from our Chapter agreed that it was a great event with a lot of enlightening content. The big news coming out of the convention is that NAHU will be changing its name to the National Association of Benefit and Insurance Professionals (NABIP) effective January 1, 2023. OCAHU will in turn change its name sometime after January 1.

I am pleased to report that OCAHU received the most awards at the NAHU Awards ceremony held at the convention on Sunday, June 26. We won the coveted Pacesetter Award, Media Relations (local Chapter), Professional Development, and for the 10th consecutive year, The William Flood Public Service Award! In addition, Maggie Stedt won the Presidential Citation for her outstanding year as CAHU President, and Meg McComb won the prestigious Distinguished Service Award for her many years of serving our association.

I would like to thank all of you who attended the Bubbles & Brunch event benefiting New Hope Grief Support. We received a lot of great comments from those in attendance. Mark your calendars for June 2, 2023, which is not only our 20th anniversary for the Women in Business event, but also New Hope's 20th anniversary! We are planning a lot of special things for that day!

I also want to welcome back our Board members, many of whom served last year. Thank you for agreeing to continue in your positions. We also welcome back John Evangelista and Dorothy Cociu. We are looking forward to a wonderful year! This year we have added a new position to the Board, a DEI (Diversity, Equity and Inclusionary) Committee Chair. Thank you, Eric Terrazas for stepping up and accepting that role.

I am looking forward to another outstanding year and welcome any questions or input from you, our fantastic members.

##

Feature Article:

What the SCOTUS Dobbs Decision Means for Employers and their Health Plans

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

The U.S. Supreme Court's ruling in the *Dobbs v. Jackson Women's Health Organization* case has caused a tidal wave of emotion and debate across the nation – especially about health care, and how it can be obtained.

The high court ruled that access to pregnancy-termination/abortive care is not a constitutionally protected right. Instead, it is up to each individual state to decide what limits (if any) to place on abortive care performed within the confines of its borders.

Some states, like Texas, which is the second most-populous state in the country, have made moves to outlaw abortion entirely. California, the most-populous state in the country, and others have made moves to make abortive care more accessible to residents and out-of-state visitors. Some have taken an array of different measures, including imposing abortion limitations based on gestational age (at varying intervals). Others have made no changes at all. With the *Dobbs* ruling, each state is handling access to abortion differently. That makes facilitating health care especially challenging.

Employer health plans cover nearly half of all Americans. Access to abortion is a health care issue. For this and other reasons, employers are being pulled into discussions about access to abortive care. Additionally, the topic is sensitive and highly divisive. The nature of the topic can have implications on employee relations, employee morale, and other areas.

Many large employers – Apple, Amazon, Citigroup, Disney, Microsoft, Netflix, and others – have made public statements about providing access to abortions to employees who reside in states where they are now limited or banned. This caught the eyes of the media (and the attention of many employees). It has prompted some employers to review abortive care benefits and travel benefits within their health plans – on both sides of the aisle.

Is Abortive Care Included in my Group Health Plan?

Each state has its own policy on whether abortion coverage must be included in benefits plans. The Kaiser Family Foundation has produced an interactive map showing each state's policies on abortion coverage.

Current California state law requires abortion coverage to be included in all private insurance plans (including employer-sponsored plans), all Affordable Care Act (ACA) Marketplace plans (on Covered California), and in all Medi-Cal plans (Medicaid plans).

Nevada state law neither requires nor limits/restricts abortion coverage in its health plans – except for Medicaid. If covered by Medicaid in Nevada, access to abortion is limited – generally available only to women in extreme medical circumstances.

How *Dobbs* Affects Health Plans

Many employers are considering adding or removing access to abortive care within their plans. The funding structure and setup of the employer's group health plan determines what the plan can do. Fully insured plans are limited in their options, while self-funded policies have many options.

Fully insured (traditional) plans are governed primarily by state law, according to where the plan is domiciled (and/or where the covered member resides). Fully insured plans must also comply with federal ERISA law, but state law preempts federal law for such plans. If an employer's fully insured plan is domiciled in a state that has blocked or restricted access to abortive care, then the health plan is generally subject to such state laws.

Self-funded plans are governed by federal ERISA law, which preempts state regulations. Therefore, self-funded medical benefits are generally not subject to state insurance laws, unlike fully insured plans. Self-funded plans have significant leeway to expand or reduce access to abortive care, regardless of state law – including travel benefits to access medical care in other areas. It is worth noting that self-funded plans are typically best reserved for large employers, usually around 200+ employees, though there are smaller groups that self-fund as well. Consultation with legal counsel is required for compliance.

Travel and lodging benefits have become a new area of interest for employers. Such benefits provide benefits for hotel, travel, etc., when accessing care in an outside area. Travel and lodging benefits can be created and administered in a number of unfolding ways – through a Health Reimbursement Arrangement (HRA), a Health Savings Account (HSA), and an Employee Assistance Program (EAP); by expanding coverage in a self-funded plan; or by providing taxable reimbursement (or bonuses) to employees.

These benefit arrangements are generally considered group health plans, which are subject to federal ERISA law – and may be subject to ACA and other applicable federal law. Each of these plan options has its own considerations and pitfalls. Compliance can be especially challenging with evolving state law and federal regulation, and consultation with legal counsel is required.

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Legislative Update:

Retirement Bill Passes Out of Committee, Long-Term Care Amendment Possible

By: David Benson - OCAHU VP Legislation

The following article was posted on the NAHU website.

The Enhancing American Retirement Now (EARN) Act passed out of the Senate Finance Committee on Wednesday. The EARN Act is meant to be the Senate version of the Securing a Strong Retirement Act of 2021, known as the SECURE Act 2.0, a bipartisan piece of legislation that passed the House in March. Now that the bill has passed out of committee, several lawmakers seek to add their amendments to the bill before it is sent to the Senate floor.

The EARN Act is legislation aimed at assisting Americans with financial planning and strengthening Americans' ability to save for retirement. The bill would permit employers to provide matching contributions to 401(k) and other tax-preferred retirement plans for employees' student loan payments as if those payments were retirement contributions, require catch-up contributions to an employer retirement plan for savers ages 50-plus to be made as after-tax Roth IRA contributions. The bill would also allow participants between the ages of 60 and 63 to contribute an additional $10,000 in catch-up contributions to 401(k) plans, indexed for inflation, and would require an employer with a 401(k) plan to permit part-time employees with at least 500 hours of service in two consecutive years to participate in the plan.

The SECURE Act that passed in March differs on some points. For example, the EARN Act would raise the age for required minimum distributions to 75, from the current 72, effective after 2031, while the House version calls for a more phased approach that would raise the age to 75 by 2033. The SECURE Act also requires employers with 401(k) plans to permit part-time employees with at least 500 hours of service in three consecutive years, rather than just two.

As lawmakers continue deliberation on what exactly to include in the final version of the bill, senators are free to try and add amendments to the legislation. One amendment has been brought forth by Senator Patrick Toomey (R-PA) that would allow individuals to use their retirement savings accounts to help pay for long-term care insurance (LTCI) services.

The new retirement plan LTCI premium payment amendment is nearly identical to legislation that Senator Toomey introduced himself. S. 2415, titled the Long-Term Care Affordability Act, would permit individuals to pay up to $2,500 each year for long-term care insurance with their 401(k), 403(b) and IRAs without a tax penalty. NAHU supports this legislation, as this bill serves as a commonsense change to enhance financial security in retirement and a bipartisan way of making long-term care insurance more accessible and affordable. S. 2415 also includes a section that would require workers to get a notice explaining how the U.S. long-term care financing system works and telling them about the existence of private LTCI coverage, but this provision was not included in Senator Toomey's EARN Act amendment.

Long-term care currently ranks as the second-greatest financial concern for Americans behind retirement savings. Long-term care describes the need for assistance with everyday tasks, and is typically non-medical and not covered by health insurance. Research shows that 70 percent of individuals over the age of 65 will require LTC services and, between the ages of 40 and 50, eight percent of people have a disability that requires long-term care services.

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NAHU Convention Awards

By: Sarah Knapp - OCAHU Awards Chair

It was great to be back in person for the Awards Ceremony at the NAHU Annual Convention! Congratulations to ***California*** and ***Orange County*** for receiving the following awards:

Landmark Award: Honors state chapters for outstanding achievements and excellence in serving their members and the industry. ***California***

Pacesetter Award: Honors local chapters for outstanding achievements and excellence in serving their members and the industry. ***Orange County***

Public Service – William F. Flood Award: Presented to a state or local chapter for excellence in public service activities. ***Orange County***

Presidential Citation Award: Presented to all state and local associations that have strengthened their membership and public outreach programs. ***California – Maggie Stedt and Brad Davis***

Professional Development – Robert W. Osler Award: Presented to a state or local chapter for outstanding achievement in promoting continuing education. ***Orange County***

Website Award: Presented to the state and local chapters with the most effective and easily used websites. ***California***

Media Relations Award: The Media Relations Award honors state and local associations for outstanding media relations. ***California & Orange County***

Media Relations Award: The Media Relations Award honors state and local associations for outstanding media relations. ***Orange County***

Distinguished Service Award: Presented to members who have contributed significantly above and beyond what is normally called for in connection with association volunteer service. ***Meg McComb***

Fixing the ACA'S Family Glitch

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

The Biden Administration has proposed a rule to fix the longstanding, problematic "family glitch" of the Affordable Care Act (ACA). The ACA pain point prevents many employees' spouses and dependents from obtaining affordable health coverage on the federal or state individual health insurance exchanges, including Covered California or Nevada Health Link.

While solving the "family glitch" is supported by most members of Congress and the health insurance industry, the White House's proposed approach to fix it is controversial and goes against typical procedural protocol. Because of this, we might not see the fix enacted the way it has been proposed. If we do, it will likely be challenged in federal court.

Comments on the White House's proposed rule are due by June 6, 2022. Word & Brown is participating in the comment period with the National Association of Health Underwriters (NAHU) and others in the industry. If the "family glitch fix" proposal does not encounter major court barriers, it would go in effect January 1, 2023. Because of the aforementioned troubles, which are explained further in this column, the "fix" will likely be altered and/or delayed.

What is the "Family Glitch"?

The family glitch centers around employees' costs for spouse and/or dependent premiums on an employer-sponsored plan. It also focuses on those spouses' and dependents' inabilities to access alternate, affordable Individual and Family coverage on a state exchange.

Under the ACA's employer mandate, applicable large employers (ALEs) must offer employees *affordable* coverage. ACA affordability is based on the employee's cost for "employee only" coverage, even if that employee has a spouse, dependents, or family members in need of coverage.

When an employer of any size makes an offer of "affordable" coverage under these standards — and offers spouse/dependent coverage (at any cost) — then no one in the entire family may access "Premium Tax Credits (PTCs)" to obtain alternate "affordable" coverage on a state's individual health insurance exchange.

PTCs are "subsidies" provided by the federal government, advanced to qualifying individuals to help pay for individual premiums for coverage purchased on a state's individual exchange. PTCs are intended to be made available to taxpayers whose health insurance premiums exceed a certain annual affordability threshold, which is 9.61% in 2022. The ACA's affordability threshold hovers at about 9.5% annually.

"Family Glitch" Example

Mike is an employee with a spouse, Carol, and they have six children. Carol is a full-time mom, and therefore does not have her own offer of employer-sponsored coverage as an active employee. Mike and his entire family need health coverage. Mike's employer offers coverage to employees, spouses, and dependents.

Mike's employer offers him a bronze-tier health plan that costs him 9.61% of his income for his premium only. Mike's employer offers spouse and dependent coverage, but pays 0% for spouse/dependent premiums.

Under this "family glitch," the offer of employer-based coverage to Mike is considered "affordable" for Mike and his entire family. As a result, neither Mike nor anyone in his family are eligible to obtain PTCs to pay for alternate, individual coverage on their state's Individual health insurance exchange. Alternatively, Mike could waive the group plan offered to him and his family, and get an Individual plan on the state exchange – but he would be responsible for 100% of the family premium(s).

Therefore, Mike's only other option to cover his family today is through the group health plan. Mike would have to pay for his spouse and six dependents' premiums entirely on his own, while also paying 9.61% of his income for his own bronze-tier coverage.

Conversely, if Mike had received no offer of coverage from his employer (for any reason), then Mike and his entire family would be eligible to obtain PTCs to purchase Individual coverage on the state exchange — if the costs to cover the family exceed 9.61% of the family's household income and/or if Mike's family's household income falls within a certain range of the Federal Poverty Level (FPL).

White House's Controversial "fix" Proposal

The Biden Administration is looking to reinterpret Obama-era statutes and regulations that created the "family glitch" in the first place. It is proposing to base PTC eligibility for spouses and dependents in this situation on "total family cost" -- rather than solely on the cost of the employee's "employee only" premium, when employer coverage is offered.

Under its "fix" proposal, the employee who has been made an offer of "affordable" coverage under the aforementioned standards would not qualify for a PTC -- which is standard practice today.

However, under the proposed fix, using the previous example with Mike, his family would be eligible for a PTC, if the cost of

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their collective premiums exceeds the affordability threshold for the corresponding year. Mike, however, would not be eligible because his employer made him an offer of affordable coverage, based on his employee-only premium.

While a "fix" is certainly needed, working through the White House might not be the best way to go about it. Changes to fiscal matters, such as PTC eligibilities and payments, are usually created by Congress -- not the White House. If an Administration can reinterpret longstanding statutes and existing rules from the IRS and Department of Treasury on previous statutes, it would open up a door for Administrations to do it again in the future -- for any area, including those outside of insurance.

Processes are very important in a Democracy, and are usually followed to the letter of the law. This proposed "fix" would break that mold, if it even makes it that far.

While Congress generally agrees a fix to the "family glitch" is necessary, it has not agreed on how to do it. The concern with the proposal is not about preventing people from obtaining affordable coverage. Instead, it's about maintaining the process for rule making -- and that the rule of law is upheld to the letter of law.

Other Considerations to Repairing the Glitch

Most families prefer to be on the same health plan -- or at least have access to the same providers, hospitals, and networks. More importantly, they also prefer to take advantage of aggregated deductibles and "out-of-pocket maximums" for the family, where applicable. While the fix to the glitch would be welcomed, employees will still weigh the extra burdens and costs involved with having one family member on an employer plan, and the other(s) on individual plans. Some may find that the loss of aggregated deductibles and out-of-pockets would make splitting the family more expensive -- even with the savings a PTC would provide.

Another big concern is employer reporting for dependent coverage. In order for this "fix" to operate, state exchanges and the IRS would need to know the type of, and costs for, employer-sponsored spouse and dependent coverage in order to determine PTC eligibility. Employers currently do not report this information. Furthermore, this fix might require employers of all sizes to report on the costs and offers of dependent coverage made. There are currently two bills moving through the federal House and Senate, which would simplify employer reporting (currently conducted by large employers only). This proposed "fix" would appear to make employer reporting more burdensome, which is something legislators are looking to repair -- not complicate. This may lead to further challenges to this fix by both legislators and employers, etc.

Lastly, it's important to note that this proposed fix would not change "affordability" of the employer mandate whatsoever. ALEs would still be required to offer eligible Full Time employees affordable coverage, based on the "employee-only" rate. An employee who receives a qualifying offer of coverage by an employer of any size will not be able to get a PTC for individual coverage on a state Exchange, even if his/her family does.

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COIN COMPLIANCE CORNER

What Agents and Your Clients Need to Know!

HIPAA Privacy & Security Enforcement Updates—

By: Dorothy Cociu, RHU, REBC, GBA, RPA, LPRT - OCAHU VP of Professional Development

Welcome to another update on HIPAA Privacy, Security, HITECH and other Federal Updates.

Roe Vs Wade Sparks Guidance on Patient Privacy & What is Protected (and not) When Using Period Trackers and Other Health Information Apps

The news of the day definitely includes the backlash of the Supreme Court ruling which overturned Roe vs Wade, and this definitely affects employers, their medical plans, and the happiness (and confusion) of their employees. I will be writing a separate article on the employer issues related to this in the near future. For now, I will update you on specific guidance issued related to this ruling as it relates to HIPAA Privacy and related laws.

On June 29, 2022, HHS issued guidance designed to protect patient privacy in the wake of the Roe decision, or more accurately, the Supreme Court ruling in Dobbs vs. Jackson Women's Health Organization, the case in which the right to a safe and legal abortion was taken away. In the aftermath, President Biden and U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra called on HHS agencies to take action to protect access to sexual and reproductive health care, including abortion, pregnancy complications, and other related care. In direct response, the HHS Office for Civil Rights (OCR) issued new guidance to help protect patients seeking reproductive health care, as well as their providers. This new guidance also includes information about what is protected and what is not when using period trackers and other health information apps on smartphones.

In general, the guidance does two things:

1. Addresses how federal law and regulations protect individuals' private medical information (known as protected health information or PHI) relating to abortion and other sexual and reproductive health care – making it clear that providers are not required to disclose private medical information to third parties; and
2. Addresses the extent to which private medical information is protected on personal cell phones and tablets, and provides tips for protecting individuals' privacy when using period trackers and other health information apps.

According to recent reports, many patients are concerned that period trackers and other health information apps on smartphones may threaten their right to privacy by disclosing geolocation data which may be misused by those seeking to deny care.

"How you access health care should not make you a target for discrimination. HHS stands with patients and providers in protecting HIPAA privacy rights and reproductive health care information," said HHS Secretary Xavier Becerra. "Anyone who believes their privacy rights have been violated can file a complaint with OCR as we are making this an enforcement priority. Today's action is part of my commitment to President Biden to protect access to health care, including abortion care and other forms of sexual and reproductive health care."

This guidance addresses the circumstances under which the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits disclosure of PHI without an individual's authorization. It explains that disclosures for purposes not related to health care, such as disclosures to law enforcement officials, are permitted only in narrow circumstances tailored to protect the individual's privacy and support their access to health care, including abortion care. Specifically, the guidance:

Reminds HIPAA covered entities and business associates that they can use and disclose PHI, without an individual's signed authorization, only as expressly permitted or required by the Privacy Rule.

Explains the Privacy Rule's restrictions on disclosures of PHI when required by law, for law enforcement purposes, and to avert a serious threat to health or safety.

OCR is also issuing information for individuals about protecting the privacy and security of their health information when using their personal cell phone or tablet. This guidance explains that, in most cases, the HIPAA Privacy, Security, and Breach Notification Rules do not protect the privacy or security of individuals' health information when they access or store the information on personal cell phones or tablets. This guidance also provides tips about steps an individual can take to decrease how their cell phone or tablet collects and shares their health and other personal information without the individual's knowledge. This guidance:

- Explains how to turn off the location services on Apple and Android devices.
- Identifies best practices for selecting apps, browsers, and search engines that are recognized as supporting increased privacy and security.

The guidance on the HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care may be found at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/phi-reproductive-health/index.html.

The guidance on Protecting the Privacy and Security of Your Health Information When Using Your Personal Cell Phone or Tablet may be found at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/cell-phone-hipaa/index.html.

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If you or your clients believe that a HIPAA-covered entity or its business associate violated your (or someone else's) health information privacy rights or committed another violation of the Privacy, Security, or Breach Notification Rules, you may file a complaint at https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

For more information on how HHS is working to protect reproductive rights, visit https://reproductiverights.gov.

HHS Guidance Issued on HIPAA and Audio-Only Telehealth

On June 13, 2022, the U.S. Department of Health and Human Services (HHS), through its Office for Civil Rights (OCR), is issuing guidance on how covered health care providers and health plans can use remote communication technologies to provide audio-only telehealth services when such communications are conducted in a manner that is consistent with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules, including when OCR's Notification of Enforcement Discretion for Telehealth - PDF is no longer in effect.

This guidance will help individuals to continue to benefit from audio-only telehealth by clarifying how covered entities can provide these services in compliance with the HIPAA Rules and by improving public confidence that covered entities are protecting the privacy and security of their health information.

According to HHS, while telehealth can significantly expand access to health care, certain populations may have difficulty accessing or be unable to access technologies used for audio-video telehealth because of various factors, including financial resources, limited English proficiency, disability, internet access, availability of sufficient broadband, and cell coverage in the geographic area. Audio-only telehealth, especially using technologies that do not require broadband availability, can help address the needs of some of these individuals.

"Audio telehealth is an important tool to reach patients in rural communities, individuals with disabilities, and others seeking the convenience of remote options. This guidance explains how the HIPAA Rules permit health care providers and plans to offer audio telehealth while protecting the privacy and security of individuals' health information," said OCR Director Lisa J. Pino.

The Guidance on How the HIPAA Rules Permit Health Plans and Covered Health Care Providers to Use Remote Communication Technologies for Audio-Only Telehealth may be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html.

OCR Announces Recognized Security Practices Video Presentation

The HHS Office for Civil Rights (OCR) is producing a pre-recorded video presentation for HIPAA covered entities and business associates (regulated entities) on "recognized security practices," as set forth in Public Law 116-321 (Section 13412 of the Health Information Technology for Economic and Clinical Health Act (HITECH). The statute requires OCR to take into consideration in certain Security Rule enforcement and audit activities whether a regulated entity has adequately demonstrated that recognized security practices were "in place" for the prior 12 months. This presentation is intended to educate regulated entities on the categories of recognized security practices and how entities may demonstrate implementation. The video will be available this summer, and an announcement is forthcoming.

In advance of the video, OCR welcomed questions that could be addressed during this presentation, and asked if you had questions about recognized security practices for the presentation. Those were due to OCRPresents@hhs.gov no later than June 17, 2022.

The Speaker is Nicholas Heesters, Senior Advisor for Cybersecurity, OCR, and the topics include:

- The 2021 HITECH Amendment regarding recognized security practices
- How regulated entities can adequately demonstrate that recognized security practices are in place
- How OCR is requesting evidence of recognized security practices
- Resources for information about recognized security practices
- OCR's Request for Information (RFI) on recognized security practices

When this video is released, I will provide information on how to view it in an upcoming HIPAA Update.

Public Comment Period Closed June 6, 2022 for HITECH Request for Information

The U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) released a Request for Information (RFI) on April 6, 2022, 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. 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.

OCR encouraged 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. The comment period closed on June 6, 2022, so we expect additional guidance in the coming months.

HHS Voluntary Resolution Agreement with the University of Southern California Settles Title IX Discrimination Complaints

In a recent action of the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), related to HIPAA Discrimination, they have entered into a voluntary resolution agree-

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California Governor Announces Plan for State to Manufacture Own Insulin

By: Jennifer Holmberg, MAOM, CEBS - OCAHU VP Communications & Public Affairs

The following article was posted on the NAHU website

The Golden State is diving into the prescription-drug business, attempting to achieve what no other state has done: produce its own brand of generic insulin and sell it at below-market prices. Governor Gavin Newsom signed an executive order in 2019 directing the relevant California agencies to look into the possibility of the state manufacturing its own prescription drugs, and last week the governor announced that action was being taken to do just that.

In a Twitter video released last week, the governor said a state budget signed last week includes $100 million for California to contract and make its own insulin. Half of the allotted funds will be put toward the development of low-cost insulin products while the remaining $50 million will support a California-based insulin manufacturing facility "that will provide new, high-paying jobs and a stronger supply chain for the drug." As of now, the state has not stated what price the state-manufactured insulin would be sold to consumers at, but it is expected to be "close to cost."

The affordability of insulin has been at the forefront of conversations about prescription drug prices in every state, as well as on the national level. According to Governor Newsom's office, approximately 4 million Californians have been diagnosed with diabetes, a disease that can destroy organs, steal eyesight, and lead to amputations if it is not controlled with insulin – but one in four people who have diabetes and rely on insulin cannot afford it, forcing many to ration or forgo the drug.

In his first act as governor in 2019, Newsom signed an executive order that instructed the Department of General Services and the California Pharmaceutical Collaborative to "develop and implement bulk-purchasing arrangements for high-priority drugs, such as those with high cost and little competition" as well as "develop a framework for enabling private purchases to benefit from the state bulk pharmaceutical purchasing."

The notion of a government getting into the business of manufacturing drugs is untested, and California would be the first state in the nation to undertake such a task. Governor Newsom says that insulin is the first prescription product that the state plans to manufacture and, if successful, will pave the way for the state to manufacture other generics that residents struggle to afford.

##

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Into the Unknown

Satisfying compliance requirements in our post-*Dobbs* world will be challenging. State and federal laws are changing, especially regarding abortive care. Many laws have been resurrected for the first time in 49 years; other states have created and are developing new laws. We can't necessarily look back to case law from 49 years ago, in a pre-Roe era, to guide us to compliance today.

The *Dobbs* decision reverses a prior January 1973 Supreme Court ruling in the *Roe v. Wade* case (and 1992's Casey). The *Roe* case preceded the HMO Act of Dec. 1973, which encouraged the development of Health Maintenance Organizations (HMOs) in America. The case also preceded federal ERISA law, which became effective in 1974. The benefits industry is significantly different in 2022 than it was pre-Roe, in 1973.

We are in entirely new waters – and unfortunately, we have more questions than we have answers at the moment. It will likely be a while before we have concrete clarity, as forthcoming litigation will be critical – and will be ongoing for years.

Sweeping federal regulation may come to get states back in sync, but that is a highly divisive, uphill political battle.

Don't Panic

Many health plans have been providing travel benefits to members, to access critical care outside their immediate areas for years. In an analogy, some are comparing abortive care to organ transplant care.

Like an organ transplant service, an abortive service is specialized care that might not be available in a specific area or state. Insurance can (and often does) help cover the cost of care for such travel, in many cases. Employers will certainly want to look at their plans' health benefits to know if travel benefits are already included. Self-funded employers may have the ability to amend their plans to add, enhance, or reduce such benefits, in consultation with legal counsel.

Employers with group health plans should always create and maintain accurate, compliant federal ERISA documentation for their health plans, as required by the law.

What are Carriers Doing?

Some health insurance carriers (issuers) have released statements to members, employers, and brokers about abortive care – others have not. Carriers are swimming in new, murky waters – just like the rest of us. More information is likely to follow from our carrier partners.

Blue Shield of California announced that it will be providing travel reimbursement program to assist its members living in states that implement restrictions/bans on pregnancy termination – for both fully insured and self-funded plans.

UnitedHealthcare has released a Travel and Lodging Benefit FAQ for its plans, and announced that additional information is likely forthcoming. ##

Compliance Corner, cont. from page 11

ment with the University of Southern California ("USC") and Keck Medicine of USC (collectively referred to as, "the KMUSC Entities"), resolving a compliance review of the KMUSC Entities' policies and procedures for responding to sex discrimination complaints made by students, employees, or patients employed by, or participating in, any KMUSC programs or activities receiving Federal financial assistance from HHS. OCR initiated the compliance review of the KMUSC Entities to assess KMUSC's compliance with Title IX in its handling of sexual harassment complaints.

"We appreciate KMUSC's willingness to work with OCR to ensure voluntary compliance with its federal civil rights obligations under Title IX. As a result, OCR and KMUSC reached this agreement, reflecting KMUSC's commitment to promoting safe and equitable patient care and a healthcare environment that is free of unlawful discrimination, pursuant to Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in federally assisted education programs or activities," said OCR Director Lisa J. Pino.

KMUSC Entities have agreed to:

- Periodically notify all students, employees, and patients engaged in, furthering, benefiting from, or responsible for any educational operation, program, or activity at KMUSC Entities of the name, title, office address, email address, and telephone number of the Title IX Coordinator and the Deputy EEO/Title IX Coordinator for Healthcare;
- Institute a new chaperone policy requiring clinicians to have a medical chaperone present while performing a sensitive health examination;
- Update employee training modules to include information regarding the requirements of Title IX in the healthcare setting, including potential Title IX issues that may arise in the context of the provider-patient relationship, the roles and responsibilities of chaperones and the identification of those health care providers who are qualified and charged with determining the medical standard of care when such issues arise in the context of a possible Title IX matter; and
- Ensure KMUSC's Title IX policy and resolution processes are fully implemented and readily available to all students, employees, and patients with respect to any educational or other University operation, program, or activity at KMUSC Entities.

To read the full Voluntary Resolution Agreement text, please visit: https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/agreements/vra-usc/index.html.

I will update you more on HIPAA & related federal updates in the next issue of The COIN! ##

OCAHU Board of Directors and Staff 2022-2023

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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*

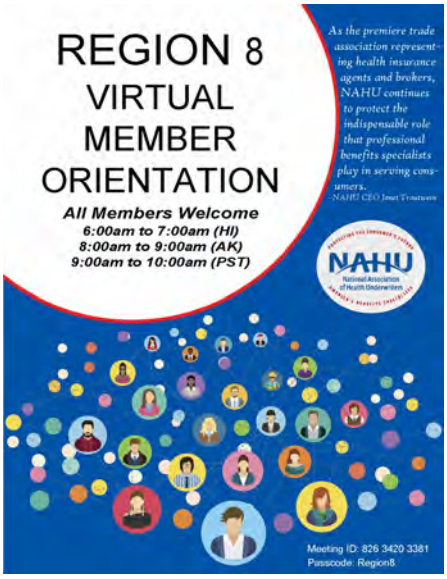
The Benefits of Membership

Joining the Association of Health Underwriters provides a lot of value to members. When you join, you automatically have access to National resources, State Level and your local chapter. Some of those benefits are outlined below. The educational piece is great for agents who are new to the industry, seasoned agents that want to keep learning our everchanging landscape and business owners who want to level up their agency. Operation Shout! is an advocacy tool that allows your voice to be heard. The lobbying arm of our organization has a great impact on the industry as a whole. Our relationships with legislative members allow us access to speak to them about pressing issues that can affect healthcare at all levels. The local chapter is a great way to network, get in-person training, exposure within the local insurance community.

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



NAHU Operation Shout!

One of the primary ways we engage in advocacy for the consumer is by supporting legislation that ensures the future and stability of the insurance industry. Through Operation Shout, you as a member have the opportunity to participate in this process. As legislative needs arise, you will be prompted by staff to participate in Operation Shout. Participating is quick and easy. To see the items we're working on and to register and participate in Operation Shout, **click here**.

Membership News

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

Celina Coffman **Michele Huerzo** **Lisa Paretsky**

Not a member? Join us today!

Contact:

Gonzalo Verduzco
☎ (714) 345-2558
✉ gverduzco@wordandbrown.com

Briana Hudson
☎ (714) 451-5772
✉ briana@dickerson-group.com

JOIN OCAHU

10th Annual Senior Summit

"Medicare: Your Journey to the Top"

By: Maggie Stedt, CSA, LPRT - Medicare Summit Chair

Over 700 agents, company representatives, physician groups and carriers will be meeting to share ideas, hear about new products and features, complete trainings including educational certifications and learn of legislative issues and concerns affecting the Medicare focused marketplace. Agents and companies have shared that this meeting is vital to their preparation and kick off for the upcoming Annual Enrollment Period (October 15th to December 7th).

There is so much to learn that the event has expanded to three full days! The program kicks off on Tuesday with Companies First Look and Product Trainings that will continue into the next day. Some of the companies include Aetna, Alignment, Anthem Blue Cross, Blue Shield of CA, Brand New Day, Central Health Plan, Centene, SCAN, UHC and WellCare.

And, to finish up the day, a fun Cocktail Party swings into action the first evening on the rooftop! On Wednesday the program is jammed packed with speakers and presenters. Thursday will be dedicated to education and break-out sessions (some with CE's).

This year we are pleased to present as our Keynote Speaker, Dan Clark, motivational Speaker extraordinaire and author of many inspirational books including ***Chicken Soup for the Soul***. He will also be leading a key workshop addressing leadership and more!

Janet Trautwein, CEO of NAHU (soon to be NABIP) will be presenting the State of Medicare on Wednesday morning.

This year is important for legislative issues on both the State and Federal levels. Especially addressing the just released CMS Marketing Guidelines for the upcoming AEP. A legislative panel with Eugene Starks (NAHU Immediate Past President), Faith Borges (California Advocates), and Nick Uehlecke (Todd Strategy) will share insights, key issues and concerns for Medicare Beneficiaries and agents.

Our educational break-out sessions will address a number of key topics that have been requested by our attendees. While being finalized at the time of the writing of this article, some of the topics include: Determining the right structure of your business (Sole Proprietor or LLC or C Corp); Addressing senior needs, Understanding and offering ancillary and supplemental benefits, Helping clients with the challenges of drug coverage, Succession planning and many more.

The Exhibit Hall opens on Wednesday morning and continues through to Thursday. It promises to offer everyone the opportunity to visit with up to 70 exhibitors to learn more about their products and services. It is always a must to visit with the exhibitors to see what is new in our industry and to connect with our carriers, medical groups and ancillary and supplemental benefit providers.

This major event would not be possible without our partners and exhibitors. A Big Special Thank-you to Applied General Agency our Gold Ribbon Partner, our Red Ribbon Partners Alignment Health Plan and Humana, our White Ribbon Partners Jack Schroeder and Assoc, Centene, Optum and Golden Outlook, our Blue-Ribbon Lunch Partners Aetna Medicare and Senior Market Sales, and our Welcome Reception Partner SunFire. An additional thank-you to HRBC, Financial Grade, SCAN Health Plan, The Brokerage, Inc. Prospect Medical, Van Berg Insurance Services, Green Leaf Financial Services, Altmed, Dickerson Insurance Services, Warner Pacific, Blue Shield of CA, AFUSA, Central Valley Health Plan, Regal Medical Group, Retire with Renewals, Rehburg Life insurance Settlements, UnitedHealthcare, and Anthem Blue Cross for their sponsorship and partnership to make this a successful Summit!

For you golfers, tee times will be available at special rates for Monday afternoon August 22nd at the Journey at Pechanga golf course. This course offers a challenging and fun playing experience.

Come and join us at this great event to learn, mingle, share ideas and just to get away and have fun! For information visit our website https:\\theseniorsummit.net. To register simply go to https:\\guestli.st\706287. Information for reserving a room directly with the Pechanga Resort and Casino is also included. For more information contact Dawn Carroll at iea-hu.adminstration@gmail.com. See you there!

##

OCAHU 2022 Strategic Planning Session

The OCAHU Board met in mid-June to plan for the new year. This is an annual half-day planning session that allows Board Members to brainstorm, strategize and set objectives around each area of focus. It was a very productive day for all.

Federal Transparancy in Coverage (TiC) Requirements: Public Rate Disclosures, Online Self-Service Tool

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

Transparency is an ongoing, major focal point in the health insurance and health care industries. Federal and state laws have been enacted across the country, aimed at making the costs of health care and health insurance more available, transparent, and digestible for consumers and the general public.

In 2020, the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury released regulations (rules) on a longstanding item within the Affordable Care Act (ACA), called **"Transparency in Coverage" (TiC)**. These regulations provided new details on the application of the complicated TiC section within the ACA, which had generally gone unenforced – pending eventual regulation. The 2020 rules introduced new forthcoming TiC enforcement dates, to be implemented in staggering intervals, beginning July 1, 2022.

The ACA's TiC section contains two major items for non-grandfathered, ACA-compliant health plans: (1) a public disclosure of in-network, out-of-network, and pharmacy costs, and (2) an online self-service tool for participants to view personalized out-of-pocket costs and other cost information for services rendered by their health plans.

In the fully insured market, compliance with the TiC items generally falls upon the *health plan*, which is administered by the carrier. Generally, carriers will fulfil the requirement. In the self-funded market, employers must ensure their plans meet these requirements on their own. The law permits employers to contract with insurance carriers or third parties for aid in TiC compliance; however, *liability* for the law cannot be transferred to another party (like an insurer or a TPA) in the self-funded space. *Note: This is a brief summarization of a complex law, and employers should always work with legal counsel to ensure full compliance with all applicable laws, specific to their own circumstances.*

TiC: Public Disclosure

The ACA's TiC section aims to enhance transparency by requiring health plans to post detailed pricing information data on a public website, for all of their covered health items/services – to be read by machines (not necessarily humans).

Per the Centers for Medicare & Medicaid Services (CMS), the disclosure data "will provide opportunities for detailed research studies, data analysis, and offer third party developers and innovators the ability to create private sector solutions to help drive additional price comparison and consumerism in the health care market."

Under the public disclosure, health plans must disclose their (A) in-network rates, (B) out-of-network allowed amounts and billed charges, and (C) prescription drug historical net prices. However, the prescription drug item (item C) is on an indefinite hold, pending forthcoming regulation at an unknown date.

The other two disclosures [items A and B above] are in effect soon. Health plans that are effective 1/1/2022 through 7/1/2022 must comply with the TiC Public Disclosure requirements by July 1, 2022. For plan years beginning August 2022 and later, compliance begins the same day as the plan year. For example, a plan that is effective 8/1/2022 must comply with the TiC Public Disclosure requirements by 8/1/2022.

Health plans must create **machine-readable files (MRFs)** to disclose this cost data, and must post the MRFs on a public website – that is not password protected or behind login. These MRFs are not intended to be consumer-facing. The data must be reported in a prescribed format, intended to be used by the data researchers' computer systems. They are Excel-like technical data files, which **must be updated on a monthly basis**. Further detail of the two disclosure items is as follows:

1. Disclosure of In-Network Rates
   - The first MRF must show negotiated ("contracted," "in network") rates for each item/service covered by the plan.
   - The MRF must also include "place of service" codes and provider tax identification numbers (TINs), especially for providers with multiple locations.
2. Disclosure of Out-of-Network "Allowed Amounts" and "Billed Charges"
   - The second MRF must show the historical payments to, and billed charges from, out-of-network providers over an (ongoing) 90-day period. The first 90-day period begins 180 days prior to the MRF's publication date – and so on.
   - An "allowed amount" is the maximum a plan will pay for a covered health care service. It is typically what a plan considers to be payment-in-full by an insurance carrier. If a provider charges more than the plan's allowed amount, a provider may sometimes bill the patient for the difference between the provider's charge and the allowed amount – a practice known as "balance billing." (Other recent federal law, the No Surprises Act, contains major initiatives to combat balance billing.)

The non-compliance penalty, which is $100/day/impacted individual, falls under the Public Health Service Act and ERISA.

Employers with self-funded plans may outsource TiC compli-

Continued on page 19

Federal Transparancy, cont. from page 18

ance to Third Party Administrators (TPAs), which is expressly permitted in the regulations. But regulators clarified – if the TPA fails to meet compliance on the self-funded employer's behalf, the employer/plan sponsor is responsible for noncompliance liability.

TiC: Self-Service Online Cost Estimator Tools

Non-grandfathered ACA-compliant plans must also create *consumer-facing*, self-service online cost estimators (due beginning January 1, 2023), which will help *plan participants* obtain personalized out-of-pocket cost information – including the plan's corresponding negotiated rates – for all health care services and items covered by the plan, including prescription drugs.

This item will be implemented in two phases. Health plans must first produce and publish a list of 500 shoppable items/services (the 500 items are prescribed by the Departments) in the tool – for plan years beginning on/after January 1, 2023, on their health plans' effective dates. Then, the following year, health plans must list all other services covered by the plan in the tool, for plan years beginning on/after January 1, 2024.

No Surprises Act: Consumer-Facing Price Comparison Tools

The federal No Surprises Act, within 2021's federal CAA law, also contains a similar consumer-facing price comparison tool requirement. And, unlike the ACA's TiC rules, the No Surprises Act *does* apply to non-ACA "grandfathered" plans. Regulators called the No Surprises Act "price comparison tool" item "largely duplicative" of the TiC self-service "online cost estimator" requirements.

In essence, it's important to understand that *all* health plans – regardless of ACA grandfathered status – will need to comply with consumer-facing pricing tools in some fashion, under either ACA and/or No Surprises Act law by 2023.

Under the No Surprises Act's Price Comparison Tool requirement, plans and issuers must make available an online price comparison tool – allowing enrolled members to compare the amount of cost sharing the member would be responsible for paying under the plan, for a specific item/service rendered by a provider. The tool must be filterable according to plan year, geographic region, and plan network. The law also requires plans to provide price comparison guidance by telephone (which is not required in TiC).

While this is scheduled to go in effect for plan years beginning on/after January 1, 2023, regulators have not yet released guidance on this item. Regulators are expected to seek comments to determine whether compliance with the TiC Final Rule satisfies the CAA No Surprises Act mandate (in addition to telephone support). For now, we await further guidance on this item from regulators.

Word & Brown is polling our carrier partners to understand their plans to meet TiC's MRF requirements; a guide will be released as soon as it's ready.

##

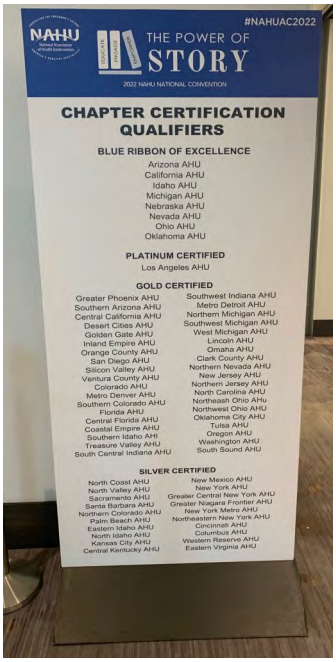
CAHIP Capitol Summit

National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

NAHU National Convention



John M. Word
Honored as Industry Person of The Year

Gordon Memorial Award Recognizes Industry's Person of the Year

NAHU honored Michael D. Gray and John M. Word III as recipients of the Harold R. Gordon Memorial Award at the organization's 92nd Annual Convention this week in Austin, Texas.

Awarded annually to the industry's "Person of the Year," the Harold R. Gordon Memorial Award is NAHU's highest honor. Winners are selected by a committee of past recipients based on the contributions they have made to the health insurance industry.

"After the pandemic prevented us from presenting this prestigious award for the past two years, I feel particularly grateful to honor two recipients who embody visionary leadership and steadfast commitment to bettering the health insurance industry," said Janet Trautwein, CEO of NAHU.

"John is a visionary and a transformative leader. He has spearheaded countless positive changes within the industry that have benefited agents and brokers and the consumers they serve," Trautwein said. "John is never complacent – he has an unrelenting drive to better his community and his industry. His efforts have left us all better off."

Word has looked for ways to improve the insurance industry from the beginning of his career. After co-founding the Word & Brown General Agency in 1985, he developed software that allowed brokers to quickly assemble information about multiple plans and find quality health insurance at the best price for their clients. Word's invention revolutionized the role of brokers in California and across the country.

Time and again, Word has demonstrated creativity and perseverance in the face of inefficiencies and complex problems.

Word & Brown created the first COBRA division in the nation, a Flexible Benefits Plans division and the "defined contribution" concept that is now used in group health plans across the country.

Word's innovative spirit and skilled problem-solving have made him an effective leader. He has served as president of the Orange County Association of Health Underwriters and the California Association of Health Underwriters. During his tenure with CAHU, he was responsible for organizing the association's first trade show. Word has also served as budget chairman of NAHU's Leading Producers Round Table.

Word has played a transformational role in his community as well. He has served on the Board of Directors at Providence Speech and Hearing for 43 years and has supported United Way of Orange County for more than two decades. Word & Brown has donated millions of dollars to these organizations and created in-house fundraising projects to help community members in need.

"As a role model for leaders in the industry and community, John could not be more deserving of this award," Trautwein said. "He has taught us to never settle for less than the best and never be afraid to think outside the box. The insurance industry would not be the same without his vision and forward thinking." ##

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 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.

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

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.

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

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.

Ease Broker Blog

Did you know Ease has a blog with valuable information that can help you and your clients? This blog is not focused on their specific technology, but some of the important topics surrounding the broker community. Below are a few recent blogs.

- Comparing HRIS and PEOs: The Conclusion
- A Deep Dive Comparing HRIS and PEOs
- Is Offering Health Insurance Right for Your Business?
- 10 Ways to Improve Well-Being at Work

If you're interested in reading more please **visit www.ease.com/blog/** and subscribe to get updates of new blog postings.

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HEALTHCARE HAPPY HOUR

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http://nahu.org/membership-resources/podcasts/healthcare-happy-hour

Latest Podcasts:

- Hear Ye, Hear Ye! NAHU Releases Summer 2022 Federal Priorities
- Supreme Court Issues Decision in Abortion Rights Case
- NAHU Submits Comments on Proposed Rule Establishing New Medicare Special Enrollment Periods
- NAHU Submits Comments on Family Glitch Proposed Rule
- CMS Releases Guidance Clarifying Broker Compensation for Special Enrollment Periods
- Genworth CEO Discusses the Ins and Outs of the Long-Term Care Insurance Industry
- Primary Palooza Sets the Foundation for Mid-Term Elections
- NAHU Discusses Medicare Marketing Final Rule with CMS
- HM Insurance Group President Mark Lawrence Discusses the Importance of Stop-Loss Coverage

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

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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
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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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- THE C.O.I.N. -

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UPCOMING EVENTS:

August 23 - 25, 2022	***10th Annual Senior Summit, Pechanga Resort Casino***
Sept 13, 2022	***CE Day, Lake Forest Community Center***
June 2, 2023	***Women In Business, Balboa Bay Resort***

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