Orange County Association of Health Underwriters

Volume 17, Issue 5
Sept/Oct 2022

2022 PACESETTER AWARD

C.O.I.N.

COUNTY OF ORANGE INSURANCE NEWS

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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

Wow! It is already September! Where did the summer go?

OCAHU, IEAHU and San Diego held an extremely successful Senior Summit at Pechanga in August. There were over 700 attendees, and the agenda and speakers were top notch. We heard a lot of good reviews of the event. Also, OCAHU got 27 new members over the 3 days!! Be sure to introduce yourself to any new members and welcome them to OCAHU. Thank you Chairs, Maggie Stedt, Yolanda Webb, Ricky Haisha, and all the OCAHU members who helped with registration and the membership table during the three-day Summit.

I am proud to announce that OCAHU will be honored at the National Philanthropy Day event as the Outstanding Philanthropic Group. The Philanthropy Awards are sponsored by the Orange County Register. The award luncheon will be held at the Grove in Anaheim on November 17, 2022. Look for an article featuring the honorees in the September 5 edition of the Orange County Business Journal. It is through the continued generosity of our members, that we are blessed to receive such a prestigious award. Thank you all!

OCAHU is proclaiming the week of October 9th as Health Insurance Awareness Week. In conjunction with that we are having a Consumer Education Program at the Lake Forest Community Center on Wednesday, October 12. We are encouraging our members to invite their clients for an informative program.

I hope you are all ready for the 4th quarter madness and I wish you the best in your endeavors!

##

Outstanding Philanthropic Group | Orange County Association of Health Underwriters

The Orange County Association of Health Underwriters is the local Chapter of the National Association of Health Underwriters and includes agents, brokers, carrier reps, and other health insurance professionals assisting individuals and employers with their health insurance needs. Ten years running, they have won the prestigious National Association's William F. Flood Award for Public Service. Through golf tournaments and the Women in Business Luncheon, they have raised $800,000+ for Cystic Fibrosis of OC and New Hope Grief Support Community. They have participated in KFI's pasta drive for Caterina's Club and hold annual holiday gift drives for children hospitalized at Kaiser and CHOC and for youth at Orangewood Children's Home.

Pat Stiffler, President

Feature Article:

New Legislation Affects Abortive Health Care in California

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

California Governor Gavin Newsom signed a package of new laws in late September that significantly affect health care and access to abortive care in the Golden State. These changes impact most Californians, especially those covered by fully insured group health plans, individual plans, or Medi-Cal.

Among the latest measures are bills that support health care providers, expand access to contraception, protect Californians from legal retaliation regarding health care services, boost uninsured care, and prohibit law enforcement and corporations from cooperating with out-of-state entities regarding abortion records in California.

In comments at the bill signing, Governor Newsom explained the intentions behind the new laws, "An alarming number of states continue to outlaw abortion and criminalize women, and it's more important than ever to fight like hell for those who need these essential services. We're doing everything we can to protect people from any retaliation for accessing abortion care while also making it more affordable to get contraceptives. Our Legislature has been on the frontlines of this fight, and no other legislative body in the country is doing more to protect these fundamental rights – I'm proud to stand with them again and sign these critical bills into law."

The health care-related measures included in the September legislative package are:

ASSEMBLY BILL 2223 - PROTECTIONS FROM CRIMINAL & CIVIL LIABILITIES: Helps ensure that pregnancy loss is not criminalized, prohibiting a person from being criminally or civilly liable for miscarriage, stillbirth, abortion, or perinatal death due to causes that occurred in utero.

ASSEMBLY BILL 2091 - KEEPS MEDICAL RECORDS PRIVATE: Prohibits a health care provider from releasing medical information on an individual seeking abortion care in response to a subpoena or request from out-of-state.

ASSEMBLY BILL 1242 - PROHIBITS COOPERATION WITH OUT-OF-STATE ENTITIES: Prohibits law enforcement and California corporations from cooperating with out-of-state entities regarding a lawful abortion in California. Also prohibits law enforcement from knowingly arresting a person for aiding in a lawful abortion in California.

SENATE BILL 523 - EXPANDS BIRTH CONTROL ACCESS: Expands birth control access – regardless of gender or insurance coverage status – by requiring health plans to cover certain over-the-counter birth control without cost sharing. Also prohibits employment-related discrimination based on reproductive health decisions. Note: The state of California does not have authority over self-funded plans. Thus, these changes generally do not apply to such plans.

SENATE BILL 1375 - TRAINING FOR HEALTH CARE PROVIDERS: Expands training options for Nurse Practitioners and Certified Nurse-Midwives for purposes of performing abortion care by aspiration techniques.

SENATE BILL 1142 - CARE WEBSITE: Requires the establishment of an abortion care services website and an evaluation of the Abortion Practical Support Fund.

ASSEMBLY BILL 2134 - HEALTH EQUITY PROGRAM: Establishes the CA Reproductive Health Equity Program, which will provide grants to providers who provide uncompensated care to patients with low-incomes and those who face other financial barriers.

ADDITIONAL MEASURES: Other legislation expedites licensure for health care practitioners coming to California to provide abortion care services, prohibits license suspension or revocation for performing an abortion in accordance with the licensee's practice, establishes an LA County reproductive health pilot project to safeguard abortion access, and creates a program to support comprehensive reproductive/sexual health education to disproportionately impacted communities.

The Governor had previously signed legislation to eliminate cost-sharing for abortion services, Senate Bill 245, and to protect those in California from civil liability for providing, aiding, or receiving abortion care in the state, Assembly Bill 1666. These measures build on the state's earlier efforts to reduce costs and expand access for those in need of abortion care services, including allocation of $200+ million to help pay for travel costs, cover uninsured care, support health care facilities and providers, and bolster security.

Governor Newsom also issued an executive order preventing medical records, patient data, and other information from being shared by state agencies in response to inquiries or investigations brought by other states or individuals looking to restrict abortion access.

Beyond what's happening legislatively, in November, California voters will face a ballot measure to decide whether to amend the state's constitution to enshrine the right to an abortion. Public opinion polls in California show a majority of voters across the political spectrum support women's rights and reproductive freedom. Still, there are groups in the state that are expected to challenge some recent legislation in court. Time will tell if any measures end up being scaled back or eliminated altogether.

##

Legislative Updates:

By: David Benson - OCAHU VP Legislation

The following articles were posted on the NAHU website.

New Bill to Allow COBRA to be Considered Creditable Coverage Introduced in House

On September 9, Representatives Kurt Schrader (D-OR), Gus Bilirakis (R-FL), Mike Thompson (D-CA), Lloyd Smucker (R-PA), Mikie Sherrill (D-NJ) and Tim Walberg (R-MI) introduced H.R. 8791, legislation that would create a one-time special enrollment period (SEP) for seniors enrolled in COBRA coverage to enroll in Medicare Part B without a penalty.

This is an issue that NAHU has been working on for quite some time. Seniors who are enrolled in COBRA coverage but are eligible for Medicare face financial penalties for not enrolling within the mandated timeframe. However, seniors who are enrolled in similar employer-sponsored plans are not penalized, as their coverage is considered creditable for Medicare.

One of the main benefits of COBRA is that it gives individuals the option to keep the exact same coverage they already had in place for an extended period. This makes it an attractive option for a person who has already met the plan's deductible or out-of-pocket expense limit for the plan year, or if the individual or the family member needs coverage of a specific prescription or treatment or is the midst of some type of extensive treatment or therapy. Electing COBRA can ensure complete continuity of care, whereas switching to a Medicare option could disrupt some medical services. There may also be a financial benefit to continue COBRA coverage when there are other family members on the plan.

Switching from a COBRA plan to Medicare can be disruptive for beneficiaries' care and may come with financial consequences for terminating their COBRA coverage early to meet the Medicare-enrollment windows.

H.R. 8791 would effectively treat COBRA as creditable coverage, allowing seniors the freedom to choose the right coverage options for them without facing a lifetime of financial consequences.

##

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.

Medicare Part B, Part D and Medicare Advantage Premiums Decline in 2023

For the first time in a decade, CMS announced that premiums for Medicare Part B beneficiaries will be lower than the previous year: Part B premiums will decrease to $164.90. The annual Part B deductible will also dip to $226 from $233.

Each year the Medicare Part B premium, deductible and coinsurance rates are determined according to the Social Security Act. The standard monthly premium for Medicare Part B enrollees will be $164.90 for 2023, a decrease of $5.20 from $170.10 in 2022. The annual deductible for all Medicare Part B beneficiaries is $226 in 2023, a decrease of $7 from the annual deductible of $233 in 2022.

The 2022 premium included a contingency margin to cover projected Part B spending for Aduhelm, a new drug meant to treat Alzheimer's. Lower-than-projected spending on Aduhelm and other Part B items and services resulted in much larger reserves in the Part B account of the Supplementary Medical Insurance (SMI) Trust Fund, which can be used to limit future Part B premium increases. The decrease in the 2023 Part B premium aligns with a CMS recommendation in May that excess SMI reserves be passed along to people with Medicare Part B coverage.

Regarding Medicare Part A, the inpatient hospital deductible that beneficiaries pay if admitted to the hospital will be $1,600 in 2023, an increase of $44 from $1,556 in 2022. The Part A inpatient hospital deductible covers beneficiaries' share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period.

The Biden administration also announced that 2023 premiums for Medicare Advantage and Part D plans will decrease. The projected average premium for 2023 Medicare Advantage plans is $18 per month, a decline of nearly eight percent from the 2022 average premium of $19.52, while Part D premiums are projected to be $31.50, a slight decrease from $32.08 in 2022.

On top of the premium and deductible decreases, beginning in 2023, certain Medicare enrollees who are 36 months post-kidney-transplant (and therefore no longer eligible for full Medicare coverage) can elect to continue Part B coverage of immunosuppressive drugs by paying a premium. For 2023, the immunosuppressive drug premium is $97.10. Additionally, Medicare beneficiaries who take insulin through a pump won't have to pay a deductible beginning July 1, and cost-sharing will be capped at $35 for a one-month supply of covered insulin. This benefit will be available to people with pumps supplied through the durable medical equipment benefit under Part B.

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2022: A Supreme Summer?

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

A Detailed Look Into This Summer's Supreme Court Decisions that Affect Employer Health Benefits and Plan Decisions

(SCOTUS Cases Dobbs v. Jackson Women's Health, Marietta Memorial Hospital Employee Health Plan v. DaVita, Inc.)

It was definitely a summer to remember, but not for the reasons most of us would think. Instead of taking extensive dream vacations, many stayed closer to home, with shorter and more cost-effective adventures, due to the high cost of flights, hotels and basic living expenses. Not to mention concern over lost luggage! With inflation at a near-record level, many were, and continue to be, on pins and needles grasping for financial relief. Coming off COVID years, we had hoped to be calmer in 2022, but instead, stress has been at a high level so far for many, with rent prices and mortgage and overall interest rates rising, the cost of basic goods and services increasing above budget-levels, and of course, the cost of gas for automobiles (not to mention jet fuels, which are keeping flight prices high) throughout the summer months. Many families have said forget vacations; I need to be able to pay for gas to get to work and groceries to feed my family!

As if all of this wasn't enough, there has been a lot in the news causing discord and overall political controversy across the nation. On June 24, 2022, although there had been rumors of it for weeks in the news after a leaked draft of the decision, the U.S. Supreme Court upheld Mississippi restrictions on abortions, in the Dobbs v. Jackson Women's Health Organization decision. As I'm sure all of you know by now, the Dobbs case overturned the Roe v. Wade and Planned Parenthood of Southeastern Pennsylvania v. Casey decisions from 1973 and 1992, respectively, which pre-empted state restrictions on abortion, and determined that access to pregnancy terminations/abortions is not a constitutionally protected right.

In another case that was decided this summer, which was announced just prior to the Dobbs decision, but was quickly overshadowed in the news and therefore in the minds of many, the U.S. Supreme Court decision on June 21, 2022 found in favor of an employer's health plan (Marietta) in a 7-2 opinion, which stated that the Marietta Hospital Employee Health Benefit Plan did not violate the Medicare Secondary Payer Act (MSPA) in limiting dialysis payments to DaVita dialysis centers. This was a huge victory for the self-insurance industry, as well as ERISA protections.

Where Dobbs caused stress and anxiety, Marietta v. Davita should have been cause for celebration for many health plans, but again, many are not even aware of this because the spotlight turned almost immediately to the Dobbs decision. I will attempt to provide information on both cases.

Dobbs v. Jackson Women's Health Organization

Before we dive into the Dobbs case, I think it's important that we look back briefly in history on cases involving federal reproductive rights.

Historical Cases Related to Federal Reproductive Rights & How They Relate to Dobbs v. Jackson Women's Health Organization

In the first case, Griswold v. Connecticut, way back in 1965, the Supreme Court ruled that a state's ban on the use of contraceptives violated the right to marital privacy. The case concerned a Connecticut law that criminalized the encouragement or use of birth control. The court determined that the Constitution does not explicitly protect a general right to privacy, the various guarantees within the Bill of Rights create what they call penumbras, or zones, that establish a right to privacy. Put together, the First, Third, Fourth, and Ninth Amendments create the right to privacy in marital relations. The Connecticut statute they said conflicted with the exercise of this right and was therefore held null and void.

This was followed by Roe v. Wade in 1973, which found that the Constitution of the United States conferred the right to have an abortion. According to Wikipedia, "On January 22, 1973, the Supreme Court issued a 7–2 decision holding that the Due Process Clause of the Fourteenth Amendment to the United States Constitution provides a fundamental "right to privacy", which protects a pregnant woman's right to an abortion. The Court also held that the right to abortion is not absolute and must be balanced against the government's interests in protecting women's health and prenatal life. The Court resolved these competing interests by announcing a pregnancy trimester timetable to govern all abortion regulations in the United States. The Court also classified the right to abortion as "fundamental," which required courts to evaluate challenged abortion laws under the "strict scrutiny" standard, the most stringent level of judicial review in the United States."

In 1992, a third federal reproductive rights case, Casey v. Planned Parenthood, the Court upheld the right to have an abortion as established by the "essential holding" of Roe v. Wade (1973) and issued as its "key judgment" the imposition of the undue burden standard when evaluating state-imposed restrictions on that right. Wikipedia summarizes that the Court overturned the Roe trimester framework in favor of a viability analysis, thereby allowing states to implement abortion restrictions that apply during the first trimester of pregnancy. In its "key judgment," the Court overturned Roe's strict scrutiny standard of review of a state's abortion restrictions with the undue burden standard, under which abortion re-

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It's Medical Loss Ratio (MLR) Rebate Check Time Again

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

The Affordable Care Act (ACA) requires group health plans to spend a minimum percentage of premium dollars on members' health care expenses and services. Likewise, it sets a threshold on the maximum amount of premium dollars that can be spent on other administrative costs, such as marketing, profits, salaries, agent commissions, etc. These requirements, known as a plan's Medical Loss Ratio (MLR), require group health plans to reimburse employers for any premium dollars that exceed MLR limits.

In the Small Group market, the law requires an MLR of 80%. That is, at least 80% of premium dollars must be spent on health care-related expenses, and no more than 20% of premium dollars may be spent on administrative expenses. In the Large Group market, the MLR rises to 85%.

Any year a health plan exceeds its MLR requirements, the health insurance carrier has until the end of September of the following year to distribute MLR rebate funds. Plans that exceeded MLR requirements in 2021 are required to distribute MLR reimbursement checks by 9/30/2022.

Employers have several options when it comes to utilizing or dispersing the MLR rebate funds, but the law gives them just 90 days to take action. Furthermore, employees are also notified about forthcoming MLR rebate checks by their plan(s) as required by law, which can also put pressure on employers.

The MLR rebate checks in the group market are generally small, ranging from about $10.00 to $30.00 per participant. Forwarding these funds to employees can be a challenge because the funds may result in additional taxable income and can be a burden on payroll. Often, the administrative cost to release the funds to employees is greater than the amount of the rebate checks themselves, which is why employers are granted flexibility when it comes to utilizing the funds.

The Department of Labor provides three options for distributing rebates:

1. Reduce subscribers' portions of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan.
2. Reduce subscribers' portions of the annual premium for the subsequent policy year for only those subscribers covered by the health policy on which the rebate is based.
3. Provide a cash refund only to subscribers who were covered under the group health policy on which the rebate is based.

The law does not require employers to track down former employees for MLR rebates, but COBRA participants must be included in any premium rebates, if applicable.

If the plan is funded solely by the employer, then the employer may keep the rebate check – as long as the rebate funds are not considered "plan assets" under ERISA law. If the funds are considered "plan assets," then the funds must be used to enhance employees' benefits. Consultation with an ERISA attorney is highly recommended for guidance in this area.

If the employer has a Section 125 Premium Only Plan (POP) in place, and its employees pay premium contributions on a pre-tax basis, then any MLR rebate amount given to those employees is generally considered taxable income. It is important for an employer to check with its accountant or payroll personnel for counsel on these tax issues. Because of these tax ramifications, most employers opt to utilize MLR rebate funds for future premium payments or apply them toward benefit enhancements for employees.

Whatever action the employer takes, a documented plan is critical – and communication of this plan is of equal importance. The employer's MLR rebate plan should clearly document and summarize the employer's 90-day action plan, should apply to all similarly situated employees, and should be available for retrieval and review by employees – and included in ERISA documentation. ##

Supreme Summer cont. from page 7

strictions would be unconstitutional when they were enacted for "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." Applying this new standard of review, the Court upheld four provisions of the Pennsylvania law, but invalidated the requirement of spousal notification. Four justices wrote or joined opinions arguing that Roe v. Wade should have been struck down, while two justices wrote opinions favoring the preservation of the higher standard of review for abortion restrictions.

Today, we have a new law of the land; the Dobbs v. Jackson Women's Health decision, where the Court upheld the Mississippi law (Mississippi Gestational Act) in a 6-3 decision, stating that "except in a medical emergency or in the case of a severe fetal abnormality," abortions are prohibited, "if the probable gestational age of the unborn human being has been determined to be greater than 15 weeks." That same case overturned Roe v. Wade 5-4.

So what does this mean? I asked my benefits and insurance attorney, Marilyn Monahan, of Monahan Law Office, to explain: "The Dobbs case overturned Roe v. Wade and Casey v. Planned Parenthood, returning the issue of whether a woman has a right to an abortion to the states. So rather than relying on a federal standard--a federal right to abortion established by Roe—it is now up to each state to determine whether the women in that state are entitled to get an abortion, and under what circumstances."

In the Dobbs case, Justice Samuel Alito, Jr. stated that "We hold that Roe and Casey must be overruled. The Constitution makes no reference to abortion, and no such right is implicitly protected by any constitutional provision, including the one which the defenders of Roe and Case now chiefly rely- the Due Process Clause of the 14th Amendment."

The end result: *No more federal protections on abortions.*

So where do we go from here, and what is the current state of the nation after this ruling? Obviously, this case resulted in high levels of emotion and debate.

State Immediate Actions on Abortion Following Dobbs v. Jackson

Amidst the media frenzy, frantic women's rights movements and shouting matches across the nation, we have had numerous state actions on both sides. Surprisingly to some, the state of Kansas, a red state, voted on an August 2, 2022 ballot measure the "Kansas No State Constitutional Right to Abortion and Legislative Power to Regulate Abortion Amendment." Simply stated, a "yes" vote supported amending the Kansas Constitution to state that nothing in the state constitution creates a right to abortion or requires government funding for abortion, and states that the legislature has the authority to pass laws regarding abortion. A "no" vote opposed amending the Kansas Constitution, thereby maintaining the legal precedent established in a prior case, Hodes & Nauser v. Schmidt in 2019 that the Kansas Bill of Rights provides a right to abortion. In a 59% majority, the NO votes won, maintaining the right to an abortion. This case also took over the news cycle for at least two weeks.

Other states with similar measures on the ballot in upcoming elections include California, Kentucky, Montana and Vermont.

State Access to Abortions

The status of state abortion access has never been more in the forefront. In a recent study by Kaiser Family Foundation, as of August 17, 2022 (this is changing frequently), abortion is banned in 9 states, status of the pre-Roe ban is unclear in 2 states, abortions are banned/restricted but not yet implemented in 2 states, abortion bans are temporarily blocked, with abortions legal in 4 states, and various other statistics. California is one of 24 states (as of this writing) and DC that have abortions widely available. This map can be found at: https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard/.

KFF also produced an interactive map showing each state's policies on abortion, which is available at: https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/.

Certain states have enacted or are considering enacting laws that greatly restrict or completely ban abortion access for women. Other states have enacted (or are considering) laws that would make it a civil or criminal violation to "aid and abet" or otherwise assist an individual in accessing abortions. Currently, these include Texas and Oklahoma. Missouri is considering expanding prohibitions on abortions on state residents performed outside of the state's borders. Texas is threatening to limit companies from doing business in their state based on covering, supporting, or permitting access to abortions.

I asked Marilyn Monahan about the current landscape in the states. "Some of the issues of most concern center on the civil and criminal penalties that some states are imposing. Various states, such as Texas, have passed or are looking into imposing civil penalties that could be levied on those who assist a woman who obtains an abortion. In other circumstances, criminal penalties could be imposed for performing an abortion, or assisting someone who obtains an abortion, when the procedure is illegal in the state. Two factors that complicate the situation are that the laws vary from state-to-state and that they are constantly changing. Whether and when these penalties might be imposed are some of the most critical open issues we are facing right now. Women seeking medical care, their families, providers, and health plans are among those who are attempting to understand and comply with the new standards that are being put in place. While many people are analyzing these issues, we don't have definitive answers with regard to a number of these questions yet."

Employer Health Plans and Dealing with Abortion

Many employers are now scrambling to make plan changes that allow for access to abortions since the Dobbs v. Jackson

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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

Much of the activities of HHS/OCR have been related to the Public Health Emergencies of COVID and Monkey Pox recently, but I will update you on cases that have been settled, and other privacy breaches, as well as provide you with other HHS/OCR news.

OCR Settles Case Concerning Improper Disposal of PHI

First, on August 23, 2022, the Office of Civil Rights announced a settlement in a case concerning Improper Disposal of PHI, where the investigation led to a $300,640 HIPAA Settlement and Corrective Action Plan. In this case, the Office for Civil Rights (OCR) at the Department of Health and Human Services announced a settlement with New England Dermatology P.C., d/b/a New England Dermatology and Laser Center ("NDELC"), over the improper disposal of protected health information, a potential violation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. As a result, NEDLC paid $300,640 to OCR and agreed to implement a corrective action plan to resolve this investigation. NEDLC is located in Massachusetts and provides dermatology services.

On May 11, 2021, NEDLC filed a breach report with OCR stating that empty specimen containers with protected health information on the labels were placed in a garbage bin in their parking lot. The containers' labels included patient names and dates of birth, dates of sample collection, and name of the provider who took the specimen. OCR's investigation, conducted by OCR's New England Regional Office, found potential violations of the HIPAA Privacy Rule including the impermissible use and disclosure of PHI and failure to maintain appropriate safeguards to protect the privacy of PHI.

"Improper disposal of protected health information creates an unnecessary risk to patient privacy," said Acting OCR Director Melanie Fontes Rainer. "HIPAA regulated entities should take every step to ensure that safeguards are in place when disposing of patient information to keep it from being accessible by the public."

In addition to the monetary settlement, NEDLC will undertake a robust corrective action plan that includes two years of monitoring. A copy of the resolution agreement and corrective action plan may be found at: https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/nedlc-racap/index.html.

OCR offers helpful FAQs concerning HIPAA and the disposal of protected health information: https://www.hhs.gov/sites/default/files/disposalfaqs.pdf - PDF

In this case, OCR actually one step further and asked the public to file a compliant if you 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. The formerly asked that complaints be filed at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

Breached Information of 2.5 Million Student Loan Accounts – Includes Social Security Numbers

In a non-HIPAA breach, but an important breach just the same, Lifelock (and other publications) reported a breach of student loan accounts to all of their subscribers. They cautioned that you should always make sure that you update any software you use, change your passwords often, and always watch out for phishing attempts.

In this Data Breach, Lifelock reported on August 31, 2022 that Nelnet Servicing, a technology service company used by Oklahoma Student Loan Authority (OSLA) and EdFinancial, announced a breach affecting 2.5 million student borrowers. Breached information included social security numbers, emails, phone numbers and addresses. If exploited, they warned that cybercriminals can use this information to target victims with spam or phishing attempts which could lead to identity theft.

Lifelock warned that whether you have been affected by this incident or not, it is always important to update your software and change your passwords often.

HHS Office of Civil Rights Celebrates National Recovery Month

In a personal statement by Melanie Rainer, Director for the Office of Civil Rights (OCR) on September 1, 2022, released a statement saying that "every September, our country celebrates National Recovery Month to highlight that behavioral health is an essential part of health care. Supporting our loved ones and communities in recovery is a critical effort and one that the Office for Civil Rights (OCR) is proud to work on to ensure that all people have equal access to health care, no matter where they live or who they are. These efforts are part of the Biden-Harris Administration's commitment to advancing health equity and civil rights, as laid out in President Biden's executive orders on Advancing Racial Equity and Support for Underserved Communities and Preventing and Combatting Discrimination on the Basis of Gender Identity or Sexual Orientation."

Rainer continued: "The Biden-Harris Administration has prioritized behavioral health care, and OCR is committed to doing all we can do help advance this mission. To that end, below are some resources to help ensure care."

HHS Video Series on Federal Disability Rights Protections That Apply to Some Individuals in Recovery from an Opioid Use Disorder

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"As part of a shared commitment to ensuring protections from discrimination apply to all people," Rainer stated, " including those in treatment for or recovery from substance use disorders, OCR has collaborated with the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (HHS), and the National Center on Substance Abuse and Child Welfare (NCSACW) to produce a video series, "Civil Rights Protections for Individuals in Recovery from an Opioid Use Disorder." The five-part series informs audiences about the application of federal disability rights laws to child welfare programs and activities, discusses protections that apply to some individuals in recovery from an opioid use disorder, provides an overview of medication-assisted treatment (MAT), and addresses common misconceptions about MAT as a treatment approach.

The video series includes:

- Two pre-recorded civil rights webinars: The first video provides foundational information on the application of federal disability rights laws to child welfare programs and activities; the second video explores federal disability rights protections that apply to some individuals in recovery from an opioid use disorder.
- A video, which provides an overview of MAT and addresses common misconceptions surrounding this treatment approach as they pertain to child welfare practice.
- Two animated videos depicting discussions around misconceptions individuals may have about MAT and how federal disability rights laws protect some individuals in recovery from an opioid use disorder.

"These resources provide needed training for personnel in the child welfare system on federal disability rights laws, and are intended for all audiences but in particular, child welfare caseworkers, social workers, service providers, parent's attorneys, agency attorneys, children's attorneys, advocates, Court Appointed Special Advocates (CASA), judges and judicial officers, Court Improvement Program personnel, Family Treatment Court personnel, substance use disorder treatment providers, and other child welfare stakeholders. The videos also inform individuals in recovery about protections they may have under federal disability rights laws. View the complete video series."

Civil Rights Enforcement

Director Rainer also released information on the OCR Enforcement activities.

"OCR is dedicated to addressing issues of discrimination in behavioral health, including discrimination experienced by historically marginalized populations. OCR is responsive to complaints from individuals in recovery who have experienced discrimination in accessing health and human services based solely on their participation in active treatment such as MAT. Over the past year, OCR has produced the following results through enforcement of federal civil rights laws, sending a strong message to the health care industry about the importance of ensuring nondiscrimination for people in recovery:

- OCR and the U.S. Attorney's Offices for the District of Rhode Island and Massachusetts reached an agreement with 12 skilled nursing facilities in Rhode Island and Massachusetts operated by Genesis HealthCare, Inc., to resolve allegations that the facilities denied admission to prospective residents because they were taking an FDA-approved medical treatment to treat Opioid Use Disorder, in violation of the ADA, the Section 1557, and Section 504."
    - Read the Press Release
    - Read the Voluntary Resolution Agreement

According to Rainer, "OCR and U.S. Attorney's Office for the District of Massachusetts reached agreement with The Oaks, a skilled nursing facility in Massachusetts operated by Life Care Centers of America, Inc., to resolve allegations that the facility denied admission to a prospective resident because he was taking a Food and Drug Administration-approved medication to treat Opioid Use Disorder, in violation of Section 1557, Section 504, and the Americans with Disabilities Act."

- Read the Press Release
- Read the Voluntary Resolution Agreement

HIPAA and Mental Health and Substance Use Disorder Treatment

Rainer stated: "Support from family members and friends is key to helping people struggling with behavioral health, but their loved ones can't help if they aren't informed of the problem. OCR has released guidance explaining when HIPAA permits health care providers and other covered entities to share a patient's health information with loved ones and others involved in a patient's care in these situations.

The guidance explains:

- Providers can share information with an individual patient's loved ones in certain emergency or dangerous situations, such as when the patient is in a crisis and incapacitated or is facing a serious and imminent threat of harm.
- Patients with decision-making capacity retain their right to decide when and whether their information will be shared unless there is a serious and imminent threat of harm.
- Patients' personal representatives, who have authority under state law to make health care decisions for patients, may request and obtain information on behalf of patients.

Read the guidance here: Guidance on Responding to an Opioid Overdose - PDF."

Biden-Harris Announce Largest Investment Ever in Navigators Ahead of Marketplace Open Enrollment

In unrelated HHS news, on August 26, 2022, the Biden-Harris Administration released information on the "Largest Investment

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Supreme Summer cont. from page 9

decision, due to employee pressure or their management's stance on the issue. Many large employers have recently made public statements that of course hit the news cycles, about providing access to abortions to their employees who may reside in a state where the state law does not allow for abortions, including Amazon, Apple, Citigroup, Disney, Microsoft and others.

What can employers do? Much of that depends on whether the employer's health plan is fully-insured or self-funded. Options being considered include a) amending existing plans to enhance or expand travel and out-of-area and expanding prescription drug benefits to cover pharmaceutical abortion options, b) offering a travel benefit by means of a secondary health plan, c) providing a medical travel reimbursement benefit through a non-traditional type of health program, d) making travel and lodging expenses reimbursable through a Health Savings Account (HSA) or Health Care Flexible Spending Account (FSA), e) establishing a separate, stand-alone travel expense reimbursement program, f) including travel expenses in an existing taxable reimbursement program.

It's important to note that travel can be a valid medical expense under certain plans. Section 213-D of the IRS code allows for travel expenses, but there are limits. There are other issues that will need to be discussed, however. Will there be a Mental Health Parity issue if the medical/surgical benefit for abortion does not match the mental health benefits? Is Aiding and Abetting a concern, or should it be?

The Dobbs v. Jackson case will impact covered services in health plans within certain states most definitely, particularly when they have significant restrictions in place on abortion. Some states will attempt to block patients and health plan beneficiaries from traveling across state lines for abortions. Others may restrict patients or health plan beneficiaries from receiving abortion-producing drugs through mail order or telehealth services. ERISA self-funded plans will likely have the most flexibility, and will likely argue that ERISA pre-emptions will protect them; at least in non-criminal cases. We'll discuss potential criminal issues below.

I asked Marilyn Monahan about the ERISA argument regarding pre-emption in the states and whether that would apply in these types of state abortion issues. "If the travel costs are part of an ERISA plan, an argument could be made that ERISA pre-empts any criminal or civil penalties that might apply under state law. That is one of the arguments that has been presented but, so far as I know, it hasn't been explicitly tested yet."

It's important to note that fully insured health plans are of course subject to state laws. Some states that do not provide for abortion coverage allow for certain abortion riders.

Let's talk first about amending existing medical plans to en-

Continued on page 13

hance travel and out-of-area benefits and prescription benefits. If self-funded, plans may be able to expand travel benefits to include travel to out-of-state providers, including network providers, in other states where abortions are legal. Before making drastic changes immediately, I'd suggest (I'm not an attorney, but I'm sure attorneys would likely agree with me on at least this) that the plan sponsor first discuss in detail with their brokers/consultants, third party administrators and benefits attorney. The benefits attorney may also suggest consultation with one or more other attorneys to be sure the plan's ducks are in a proverbial row. Does the plan already cover travel for benefits and if so, what are the current restrictions? Does the plan even cover abortions now, and if so, does it allow for surgical abortions, pharmaceutical abortions (i.e. the morning after pill) or both? Do the states that plan participants would be likely to travel to or from contain laws such as criminal penalties against aiding and abetting or other criminal laws that could get pulled into this? Does the plan currently cover pharmaceutical abortions in your drug plan? What about your telehealth plan?

"If you are adding travel benefits to your plan, you want to make certain that the travel benefits are structured to comply with any limitation contained within Section 213(d) of the Internal Revenue Code, as well as any other rules or limitations that might apply," stated Marilyn. "For example, if you're reimbursing mileage, there is a specific standard reimbursement rate for medical purposes, which is different from the business reimbursement rate that the IRS announces every year. Also, there are limitations on reimbursements for lodging. While you can reimburse lodging expenses, the Code imposes certain limitations on the terms and conditions under which you can do so, as well as a limit on the total amount you can reimburse. You generally can't reimburse meals, unless they are part of inpatient care."

Fully insured plans are of course limited to the insurance carrier provisions and state laws, so the plan sponsor's choices may be more limited.

Does it make sense to look at a travel benefit through a separate health plan, or a medical travel reimbursement? Can it be added to existing or newly added EAP programs, telehealth programs, HRA or FSA plans? Again, consultation with the broker consultant, TPA and one or more attorneys is recommended because of issues or potential issues with a variety of laws, including the ACA, COBRA, HIPAA Privacy & Security, etc. Many of these arrangements are considered group health plans, so ERISA and these various other federal laws may be applicable.

I recently discussed this with Jeff Strong, Vice President of Sales, Sterling Administrators. "As an HSA, FSA & HRA administrator, we have seen a lot questions and inquires into the travel for abortion due to the system change and now it being legal in some states and not in others," commented Jeff. "Right now it is a bit of a moving ball; it reminds me a lot of the early days of the ACA with continual change. Dorothy had talked about all the tools that are defined and out there through IRS section 213 and blanketed by IRS Revenue Ruling 73-201. One thing we recommend to keep in mind is the definition of abortion being legal in that state. Where the challenge resides is in the definition of 'legal' in the state. Is the legal state the one where the medical care is, or if the employee is in a state that abortion is not legal and the company is situs in that state would it make it not legal to reimburse for claims and expense for travel to a legal state? If one gets drugs for abortion is it where they get the drugs, or where the drugs start to work? Then finally, how much enforcement will there be with this? Employers with a strong legal arm will find they are busy as things continue to change and there is not a clean line of sight at this time."

Would the employer benefit from an outside stand-alone plan for travel expenses? In all travel plans, you need to look at reasonable expenses for each expense, including mileage rates, lodging rates, whether it would be tax-free or taxable, etc. A broader travel plan may be wise.

"It could be advantageous to make your travel reimbursement policy broader than just applying it to abortion services," stated Marilyn. "You need to look at the big picture and consider whether you should extend travel benefits to other covered items and services, such as centers of excellence, transplant centers, and the like. When designing these benefits, remember that one size does not fit all." As Marilyn and I discussed in a recent podcast (Benefits Executive Roundtable, Season 4, episodes 1 and 2), employers should not be rushing to make decisions. Take a deep dive with your broker consultant and related vendors (including your attorney) and consider all of your options.

California State Laws Related to Abortions

As of now, California state law requires that all private insurance plans cover abortion coverage, including full-insured group health plans, ACA Marketplace plans and in all Medi-Cal plans. Self-funded health plans in California are of course subject to federal ERISA laws, and are pre-empted from state mandates (more to come on how far that pre-emption will go related to abortion issues).

Primary Legal & Possible Criminal Issues

I will attempt to frame some of the most important legal issues today related to abortions and crossing state lines to get them.

In a nut-shell, federal laws in place include of course ERISA (and the pre-emption issues that go with that), as well as the Pregnancy Discrimination Act issues, which was passed in the 1970s and requires plans to cover abortions if the life of the mother is at risk. There are of course restrictions on travel benefits, no matter how and in what type of plan they are included in.

Let's talk more about the potential for other legal issues, including possible criminal issues, which I mentioned briefly above. Some states have and more will be adding criminal liabilities for people who assist someone in getting abortions. Some have existing and others are considering adding aiding

Continued on page 17

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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 Value of Your Membership

By: Gonzalo Verduzco - OCAHU VP Membership

What do you get for your investment as an Orange County Association of Health Underwriters (OCAHU) member?

Legislative Updates and Alerts

Through communication and membership meetings, we keep your finger on the pulse when it comes to healthcare reform and upcoming changes.

Professional Development

We are committed to helping agents and brokers reach new heights in their careers through Continuing Education course, seminars, conferences and more.

Networking

OCAHU provides a rich forum for sharing ideas, asking questions and learning new technologies.

And it doesn't stop there!

- National Association of Health Underwriters (NAHU) will protect your right to serve your clients needs.
- You will obtain timely, informative news
- You will attend continuing education seminars on the hottest insurance topics, locally, statewide and nationally at a discount.
- You will share information with top producing insurance professionals.
- You can participate in grassroots efforts that respond to local, state, and federal legislative issues.
- You will benefit from a variety of member-only discount programs.
- NAHU's Code of Ethics demonstrates to your clients your commitment to professionalism.
- You will play an active role in the future of the health insurance industry.
- You will receive a subscription to America's Benefit Specialist, the National Association's monthly magazine, and bi-monthly OCAHU newsmagazines.
- With NAHU following trends in Large and Small Group Managed Care Plans, Individual Health Plans, Long Term Care Insurance, Disability Insurance, and Medicare, you will benefit from membership no matter your specialty.

Membership News

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

Patricia Ahoia	**Chu Kyugah**	**Maria Perez-Flatt**
Irene Alzate	**Silvia Larin**	**Brandon Roberto**
Theresa Angulano-Redd	**Jose Lopez**	**Veronica Sandoval**
Gary Been	**Amanda Lundberg**	**Rodney Shepherd**
David Butrum	**Jerry Lynch**	**Carolyn Troutman**
Carol Chamberlin	**Alpa Maniar**	**Melinda Vazquez**
Aaron Charney	**Ellen Miller**	**Nick Vucurevic**
Vicky Chow	**Pete Pacheco**	**Autumn Wright**
Gary Culp	**Irene Paredes**	**Pascal Zandt**

Not a member? Join us today!

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JOIN OCAHU

10th Annual Senior Summit

"Medicare: Your Journey to the Top"

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

We are pleased to report that 770 agents, company representatives, physician groups and carriers gathered at the Senior Summit held at the Pechanga Resort and Casino. They shared ideas, heard about new products and features, completed trainings, attended educational certifications, and learned of legislative issues and concerns affecting the Medicare focused marketplace.

The biggest news is that our Membership team brought in 63 new members for several of our chapters with 33 of them for OCAHU!!!!! Our membership table was manned the entire event and made the difference! Thanks to Gonzo Verduzco and his team including Briana Hudson, John Evangelista, Pat Stiffler, Dorothy Cociu, Dave Benson and more! NAHU congratulated us for the great effort!!!!

On Monday afternoon, 10 foursomes gathered for a round of golf. Juan Lopez reported all had a great time with recognition given for closet to the pin for both men and women. The winners of the mini tournament were Juan Lopez, Ricky Haisha and John Morales with a minus 7 in a card off.

On Tuesday the event was kicked off by Alignment with a high energy training followed by Product First Looks with SCAN, Humana, Blue Shield, Aetna, Brand New Day, Central Health and product trainings with Wellcare and Anthem. NAHU's CEO Janet Trautwein gave an update on NAHU's CMS and Legislative actions. Nick Uehlecke from Todd Strategy Group shared a Medicare update from Washington DC. Patrick Rodriquez, Principal of AGA our Gold Ribbon Partner, shared the importance of NAHU membership for the Medicare Agent. We finished up the day with a jammed packed fun Cocktail Party on rooftop in the Eagle's Nest!

On Wednesday the program was kicked off by SilverSneakers' Maria Arana with yoga and was followed by a CE class with James Russ. After a formal opening and recognition of our dignitaries, attendees were welcomed by CAHIP President Sue Wakamoto-Lee. We heard messages from our Ribbon Partners: Gold- AGA, Red - Alignment and White- Golden Outlook, JSA, Optum and Wellcare. Janet Trautwein returned with an up to minute update from NAHU and a call to action. Next up was our Keynote Speaker, Dan Clark, motivational Speaker extraordinaire and author of many inspirational books including Chicken Soup for the Soul.

Our exhibit hall opened up with over 70 exhibitors and was well attended throughout the Summit. The new expanded layout was found easier to navigate. A big thanks to our exhibitors for participating! In the afternoon we addressed important state and federal issues especially addressing the just released CMS Marketing Guidelines for the upcoming AEP. Nick Uehlecke returned with more updates and Dwane McFerrin from SMS shared information about the work by NAHU FMO Council and Medicare Advisory Group on our members' behalf. A legislative panel with Susan Rider, NAHU Treasurer, Faith Borges of California Advocates, Sue Wakomoto-Lee and Dwan McFerrin, shared insights, key issues and concerns for Medicare Beneficiaries and agents.

We finished the day with a few minutes with Golden Outlook, Jack Schroeder and Associates (JSA), Wellcare and Optum. United Healthcare provided an hour presentation for their Medicare Advantage, PDP and Medicare Supplement 2023 Product Rollout.

The day started on Thursday with SilverSneakers Cardio Fit Express Training. We heard messages about NAHU Membership and HUPAC. We then jumped into our Prescription Drug Panel: Challenges and Options with Dr. Sarah Chae, Dr. Sherrill Brown, Tami Mongold and Bill Hepscher.

Our White Ribbon partners Wellcare and JSA returned to share some additional insights. Alignment conducted a fun "Oscar" recognition for performance for MAPD plans. Dan Clark returned to share How to Network and Influence through Speaking and Storytelling.

The morning was closed out by the Senior Summit Executive Committee with Thank-you's, recognition of our volunteers and awarding of the Grand Prize sponsored by Van Berg Insurance Services.

The afternoon was dedicated to our educational/informational break-out sessions that addressed a number of key topics that had been requested by our attendees. A big thank-you to the following presenters: Karina Romero, Bill Hepscher, Wayne Goshkarian, Danniel Wexler and Phil Calhoun, Lucy Niquet, Craig Taylor, Dale Stein, Lisa Ramsey, Aaron Kassover and Craig Gussin!

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. Additionally, a 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!

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Senior Summit cont. from page 16

Your Executive Team (Yolanda Webb, Ricky Haisha, Juan Lopez, Henry Romero, Craig Gussin and myself with Gale James Clarke, Dawn Carroll and George Carson) put in countless hours of work to help make this Summit one on the most well attended in all of NAHU. A special thanks to Gail James Clarke, Dawn Carroll and George Carson for their support and expertise. We would not have succeeded without them!

Mark your calendars for next year! The event will return to The Pechanga Resort and Casino on August 22nd to the 24th. It promises to be even better! (Yes, we take the surveys and comments seriously!) Juan is also looking forward to the return of the Official Summit Golf Tournament! Partners, exhibitors and sponsors, please start planning and budgeting now to participate! More information should be out no later than April 1st! ##

Compliance Corner, cont. from page 11

Ever in Navigators Ahead of Healthcare.gov Open Enrollment Period."

According to HHS, the US Department of Health & Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), is investing $98.9 million in grant funding to 59 returning Navigator organizations for the 2023 Open Enrollment Period to help consumers navigate enrollment through the Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP), and to make health coverage more equitable and accessible to everyone.

Does anyone else wonder if this massive spending in Navigators will hurt agents? ##

Supreme Summer cont. from page 13

and abetting laws related to abortions.

In a state such as Texas, could an Uber or Lift or taxi driver be held liable for driving a patient across one or more state lines to receive an abortion? It's certainly possible with current aiding and abetting laws. What if it's your spouse, your sister, your daughter, your cousin, or a close friend that you've had discussions with about whether to get an abortion? What about a health benefit broker/consultant and/or their benefits attorney discussing the pros and cons of health plan provisions that could potentially circumvent state laws disallowing abortions and finding ways to get the abortion covered under the health plan? Does that broker/consultant or attorney, simply providing information on what states allow and do not allow certain types of abortions have liability? Would a plan's Third-Party Administrator have liability if they discussed certain scenarios with the plan sponsor or covered plan beneficiaries? Would there be TPA or PBM liabilities for shipping or delivering abortion pharmaceutical drugs? Again, I referred to Marilyn for her opinion.

"I'm not a criminal lawyer, but I do understand that the potential for criminal liability is one of the areas, for example, that doctors are worried about. This could also potentially be an issue for health plans, if states that outlaw abortion view payment for abortion services to constitute aiding and abetting a criminal act. For example, could a state deem a health plan to have aided and abetted a criminal act if the health plan pays the expenses for a woman to travel from a state that outlaws abortion to one that permits abortions? These issues could also arise in the case of a medical abortion. We don't really have definitive answers to these questions."

Biden Administration Guidance & Executive Orders to Protect Access to Abortion & Contraception

Just two weeks after SCOTUS' decision in the Dobbs v. Jackson case, President Biden signed an executive order to protect a woman's access to reproductive health care services. The only way to truly secure that right, of course, would be to restore Roe v. Wade, but the Biden Administration says it's committed to defending reproductive rights and protecting access to a safe and legal abortion.

The executive order contains a 5-point action plan in response to the Dobbs v. Jackson case. These steps include safeguarding access to reproductive health care services, including abortion and contraception, by directing Secretary of Health & Human Services' Xavier Becerra, to report to him within 30 days on efforts to protect access to medication abortion, ensure all patients have access to the full rights and protection of emergency medical care, expend access to a full range of reproductive health services, including family planning services and providers, including access to emergency contraception and long-acting reversible contraception like IUDs. As these are preventive services, they should be covered with no co-pay under the ACA for non-grandfathered plans. Given the current state of the divided houses in Congress on this issue, I'm not convinced anything will happen on this any time soon, but they have promised something will be forthcoming in the way of regulations or guidance. How far the guidance will go and what precise guidance will be issued is unknown. We'll have to wait to see what HHS develops.

Marietta Memorial Hospital Employee Health Plan v. DaVita, Inc.

The first of the two SCOTUS decisions, which again was overshadowed by the Dobbs case, was the Marietta Memorial Hospital Employee Health Plan v. DaVita, Inc.

This case, which mentioned above, hit the news on June 21, 2022, and found in favor of an employer's health plan (Marietta) in a 7-2 opinion. In this case, which stated that the Marietta Hospital Employee Health Benefit Plan did not violate the Medicare Secondary Payer Act (MSPA) in limiting dialysis payments to DaVita dialysis centers, was a big win for self-funded health plans.

Brief History/Background of DaVita cases

DaVita v. Marrietta Hospital was one of three federal appeals court cases by DaVita, challenging plan sponsor's authority to

Continued on page 20

Group Health Plan Compliance Requirement Due 10/15

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

Employers (of any size) providing prescription drug coverage benefits must distribute an annual notice to all Medicare-eligible individuals by October 15th – including both employees and dependents. This important notice helps Medicare-eligible individuals make decisions about their health plans, drug coverage, and/or Medicare enrollment, so they may attain the best coverage for their health needs and avoid potential noncompliance penalties in the Medicare space.

When a person becomes eligible for Medicare (usually at age 65), that person must generally enroll for Medicare coverage upon initial eligibility, or a noncompliance penalty could be on the horizon. However, many people can delay this requirement (and its related penalty) by attaining qualified (non-COBRA) coverage through a qualified group health plan in lieu of Medicare.

In order for that coverage to be qualified, the employer's coverage must be considered "creditable." That is, the (non-COBRA) group health coverage must provide benefits that are at least equal to (or richer than) the benefits provided by Medicare.

Employers must disclose to all Medicare-eligible individuals whether the drug benefits provided in the employer's plan are "creditable" or "non-creditable," when compared to Medicare Part D's drug benefits. Employers must distribute a notice describing this disclosure each year before October 15th, ahead of Medicare's Annual Election Period (AEP).

During this AEP, Medicare beneficiaries and Medicare-eligible persons can enroll in, or change, Medicare Advantage plans, Medigap plans, or Medicare Part D Prescription Drug coverage plans. The information contained in the employer's disclosure helps the Medicare-eligible person make decisions about enrollment in Medicare Part D drug plans.

A Medicare-eligible person who does not enroll in Medicare Part D Prescription Drug Coverage when first eligible will face an eventual late enrollment penalty for the entire time he or she is enrolled in Medicare Part D coverage, unless that person has qualifying "creditable" drug coverage from an employer plan. The penalty is assessed upon any person who does not maintain creditable coverage for more than 62 days after his/her initial Medicare enrollment period.

Employers are likely to turn to their health insurance brokers for help determining whether the prescription drug coverage they sponsor is creditable. They may also seek an understanding of what to distribute to employees and model notices that should be used – and when everything should be distributed.

Medicare Part D Charts – Creditable or Non-Creditable Designation

We've surveyed our carrier partners and have placed creditable/non-creditable designations in easy-to-reference charts for all carriers' Small Group and Large Group plans. Refer to these charts to determine whether the coverage sponsored by the employer is creditable or non-creditable:

California – Small Group Plans

California – Large Group Plans

Creditable Coverage Model Notice

The Centers for Medicare & Medicaid Services (CMS) provide model notices to meet these distribution requirements, along with additional information on the required distribution. The model notices **must** be customized by the employer, as indicated on the model notices, before the employer releases them to Medicare-eligible individuals. There are different notices for creditable coverage and non-creditable coverage. The forms are also available in Spanish.

CMS Online Reporting Requirement for Employers

Employers providing prescription drug coverage to Medicare-eligible individuals must also submit an online disclosure to CMS annually, and upon any change that affects creditable status. The disclosure is due no later than 60 days from the beginning of a plan year, within 30 days after the termination of prescription drug coverage, or within 30 days after any change in creditable coverage status. This disclosure is required whether the employer-sponsored group coverage pays primary or secondary to Medicare coverage. ##

NAHU HEALTHCARE HAPPY HOUR

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- NAHU Submits Responses to CMS Medicare RFI
- Biden Administration Releases Third Surprise-Billing Rule and "TiC" Guidance
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- What's in the Final Version of Democrats' Reconciliation Package?
- Primary Results Shape 2022 Midterm Election Outlook
- ACA Faces New Legal Challenge

October 10-15, 2022

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CALIFORNIA'S BENEFIT SPECIALISTS

HEALTH INSURANCE AWARENESS WEEK

Join Us to Celebrate Our Industry!

SPECIAL EVENT!

Consumer Education Day

The Dark Colors of Compliance Administration

[1-HR CE Pending - 11:30 AM to 12:30 PM]

Speaker: Jeff Strong, Vice President Sales, Sterling Administration

We will be discussing unique challenges like:

- COBRA, family members and how all that works,
- COBRA, military, all the avenues that are in play,
- ICHRA, where is it going? Subsidy and all,
- HSA, FSA & HRA and abortion, travel and where is everything at with this,
- 5500's; how does one always get audited?

Followed by Congressional Candidates addressing upcoming elections!

WEDNESDAY
October 12, 2022

Lake Forest Community Center

11.00 AM - 2.00 PM

Marilyn Monahan, Esq.
Attorney
Monahan Law Office

Jeff Strong
Vice President Sales
Sterling Administration

Dorothy Cociu, RHU
President
Advanced Benefit Consultint
& Insurance Services

ASK THE EXPERTS PANEL [12:50 TO 1:50 PM] - Submit questions in advance.

REGISTER YOURSELF OR RESERVE A TABLE OF 6 FOR YOU AND YOUR CLIENTS!

For more information go to: http://ocahu.org/event-4939682

carve out benefits for high-cost treatments under the Medicare Secondary Payor Act (MSPA). In 2020, two out of three judges announced a new interpretation of the MSPA, which turns it into an antidiscrimination law that prohibits plans from taking financial risks into account in designing benefits for members who have end-stage renal disease (ESRD). The plan and administrator asked the full court to reverse that decision. The Self-Insurance Institute of America (SIIA) joined other industry stake-holders in co-sponsoring an amicus brief in support of a petition for reconsideration in DaVita v. Marrietta Hospital.

Marietta Hospital is an opinion from the federal Sixth Circuit that was a dramatic departure from precedent and long-established deference to plan sponsors in plan design, according to SIIA. The other two cases related to these issues were DaVita v. Amy's Kitchen and DaVita v. Virgina Mason, both in the Ninth Circuit. Marietta hospital was not biding on them.

The MSPA has always been interpreted as the statute defining the basics of coordination of benefits with Medicare for plan members that are entitled to dual plan/Medicare coverage for any reason. Dialysis companies have for some time promoted a competing theory that what Congress really intended was for the MSPA to prohibit plans from discriminating against members who have end stage renal disease. (Incidentally, from my own personal experience in seeing self-funded health benefit claims over the years, DaVita is widely known in the industry as a primary over-charging chain of dialysis centers, with prices far exceeding usual, customary and reasonable rates. With the increase in self-funded plans moving to some sort of reference-based pricing, which uses a percentage over Medicare rates for claim payment, such as 130-175% of Medicare rates, we've seen the charges of DaVita escalate even more. If comparing to Medicare rates, I've seen DaVita's bills exceed 1,000% of Medicare, and even as high as 2,000% of Medicare rates). DaVita's alternate theory that it was promoting was that for members who have ESRD, by paying dialysis benefits differently from the way other benefits are paid, such plans were discriminating against dialysis claim payments. To date, no court or regulatory agency had ever interpreted the MSPA that way. SIIA then co-sponsored amicus briefs in all of the cases above in support of the self-funded group health plans. The goal of the DaVita theory was to increase dialysis provider revenues by preventing plans from implementing any kind of cost containment provisions. The worst part of it was that over the years, dialysis costs have seen severe inflation, and only two providers (DaVita is one of the 2) controls nearly 90% of dialysis facilities (i.e. a major near-monopoly). The dialysis charges have traditionally been so high that even PPO discounts can't offer plans much relief. Self-funded health plans therefore adopted cost containment strategies, including network carve-outs and Medicare-rate based pricing (RBP). DaVita sued health plans using this method arguing that any dialysis cost containment strategy violates the MSPA.

In the 2020 opinion in the Marietta case, 2 of 3 judges accepted the theory of DaVita and held that the MSPA is an antidiscrimination statute that prohibits sponsors from carving dialysis out of the network and requires dialysis benefits to be paid at the "same" rate as other benefits. Under that opinion, plan sponsors could not take financial risks into account in dialysis benefits. If a plan treated dialysis differently from other benefits, for any reason, the courts are to order the sponsor to re-write the plan.

The 2020 opinion also allowed dialysis providers to sue plans directly if a member should terminate plan coverage before the end of the coordination period. The prior opinion assumed that the plan's failure to comply "forced" the member to "switch" to Medicare. The opinion basically let a provider sue for twice the amount of anything Medicare paid for any service the plan would have covered, not just the dialysis, after the member terminated plan coverage.

SIIA and other stakeholder's view of the 2020 opinion was a serious break from all precedents not only on the MSPA, but from established ERISA laws and principals deferring to plan sponsors in benefits design. SIIA feared that while the case officially limited to members with ESRD and dialysis, since the MSPA also applied to members eligible for Medicare due to age or disability, it could open the door to suits for preferential benefits for almost all serious medical conditions. SIIA and other stakeholders felt that this opinion did not consider any of those factors, and suffered from a number of basic legal flaws.

DaVita V. Marietta Hospital, June 21, 2022 Decision

Much to the relief of the Self-Insurance Industry, as well as self-funded plan sponsors and the ERISA world in general, the Supreme Court, in a 7-2 decision, found in favor of arguments put forward by SIIA and other industry participants in the DaVita v. Marietta Hospital plan case, finding that the Marietta Hospital Employee Health Benefit Plan did NOT violate the Medicare Secondary Payor Act (MSPA) in limiting dialysis payments to DaVita, because it provides the same benefits, including the same outpatient dialysis benefits, to individuals with and without end-stage renal disease. The Court upheld that group health plans like Marietta's can utilize cost-control designs under the MSPA so long as the plans offer the same terms of coverage for outpatient dialysis to all of its participants.

I asked Marilyn Monahan to summarize the case for us: "Under the Medicare Secondary Payer Rules, one of the things a plan cannot do when structuring and designing its benefits is "take into account" that someone is eligible for or entitled to Medicare, whether the person is on Medicare due to age, disability, or ESRD. In short, when structuring benefits, the plan cannot do so in a way that would treat someone who is on Medicare differently from someone is not on Medicare. Under the facts of the Marrietta case, Marietta was a self-funded health plan and DaVita argued that the Murietta health plan set very low reimbursement rates for dialysis services, and DaVita argued that this was a violation of the Medicare Secondary Payer rules. The Supreme Court determined that it wasn't."

This case, again one of 3 federal appeal cases by DaVita, challenged the authority of plan sponsors to carve out benefits for

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Supreme Summer cont. from page 20

high cost treatments under the MSPA. The court's decision can be found at: https://www.supremecourt.gov/opinions/21pdf/20-1641_3314.pdf.

The June 21, 2022 decision by the Supreme Court ensures that self-funded plan designs can continue to appropriately manage and pay for dialysis treatment for patients, without unnecessary payment increases to dialysis providers.

I asked Ryan Work, Senior Vice President, Government Relations of the Self-Insurance Institute of America (SIIA), what the Davita case does for the self-insured industry. "The Supreme Court decision in the DaVita case ensures that self-insured plan designs can continue to appropriately manage and pay for dialysis treatment for patients, without unnecessary payment increases to dialysis providers. SIIA is pleased that the ruling confirmed the ability of health plans to provide common-sense cost containment measures when it comes to high-cost services such as dialysis for those patients that need it the most. Nothing about this decision impacts the quality and care of patients, rather it allows plans to better serve all patients and continue to provide quality, affordable benefits."

The coordination of benefits issue with Medicare Secondary Payer rules has always been a sticking point with many self-funded health plans. "It is clear that the MSPA outlines coordination of benefits with Medicare for plan members entitled to dual plan/Medicare coverage for any reason," stated Ryan. "For some time, dialysis companies have promoted an idea that Congress intended the MSPA to restrict group health plans from setting reimbursement rates for dialysis services at anything other than an unspecified 'most favored nation' rate, which simply drives up costs unnecessarily."

So, what is the bottom line for the Murietta v. DaVita decision for self-funded health plans? Marilyn Monahan stated: "Here is the bottom line: As a result of the DaVita case, self-funded health plans now have more flexibility in how they set rates for dialysis reimbursement."

Ryan Work and SIIA were obviously very pleased with the outcome. "Under DaVita's interpretation of the MSPA, self-insured plans, which generally have great flexibility in determining healthcare coverage, would have to sacrifice coverage of other medical services to pay for dialysis services at a rate hundreds of times that of Medicare. These substantial cost increases would not benefit individuals with end-stage renal disease, who would continue to receive the same services. Nor would it save Medicare money. Rather, it would financially benefit dialysis providers."

Ryan continued: "With only two dialysis providers controlling nearly 90% of dialysis facilities, it is becoming increasingly necessary that self-insured health plans have the ability to appropriately control dialysis cost, which have risen exponentially against inflation," stated Ryan. "Put simply, plans adopting cost containment strategies such as network carve-outs and Medicare-rate based pricing, should not be in violation of the MSPA".

Conclusion

The summer is coming to end, but the stress of 2022 is not over. We're still dealing with inflation, high gas prices, high interest rates, increasing rent and mortgage costs, the overall cost of goods and services increasing, often beyond family budgets. Many people I know that were retired have gone back to work, at least part-time, just to survive. As we tighten our purse strings or wallets and re-examine our spending and savings habits, we should pay close attention to what's happening around us; both in the news and in our communities. We may discover that by paying closer attention to details, we may yet find at least a glimmering light at the end of the tunnel.

With the Dobbs v. Jackson case still hovering over us, we have a lot of unanswered questions, and only time and many court and other decisions will determine the fate of many unanswered questions. Employers should not be rushing to make any quick decisions on health plan changes regarding abortion coverage just yet. Take some time, breathe, and have some conversations with trusted brokers, consultants and attorneys, and see what the states and the Biden Administration bring to the table in the next few months.

The DaVita case, however, should be a relief to many in the self-insured industry, and plan sponsors should be in a much better mood after this decision. On a personal note, and on behalf of my own self-insured clients, I am relieved that at least some of the high pricing of dialysis centers who have historically overcharged health plans have been curtailed from at least some of these practices.

As for self-funded health plans and other ERISA plans, you may be able to take a look at your plan benefits to see what cost containment provisions you can add for high-cost benefits, and seek the advice of reputable consultants and experts.

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Disclaimer: This article is not intended to provide legal advice of any kind. We always recommend that you seek the advice of legal counsel before finalizing plan decisions.

Senior Summit & CAHU Leadership Photos

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.

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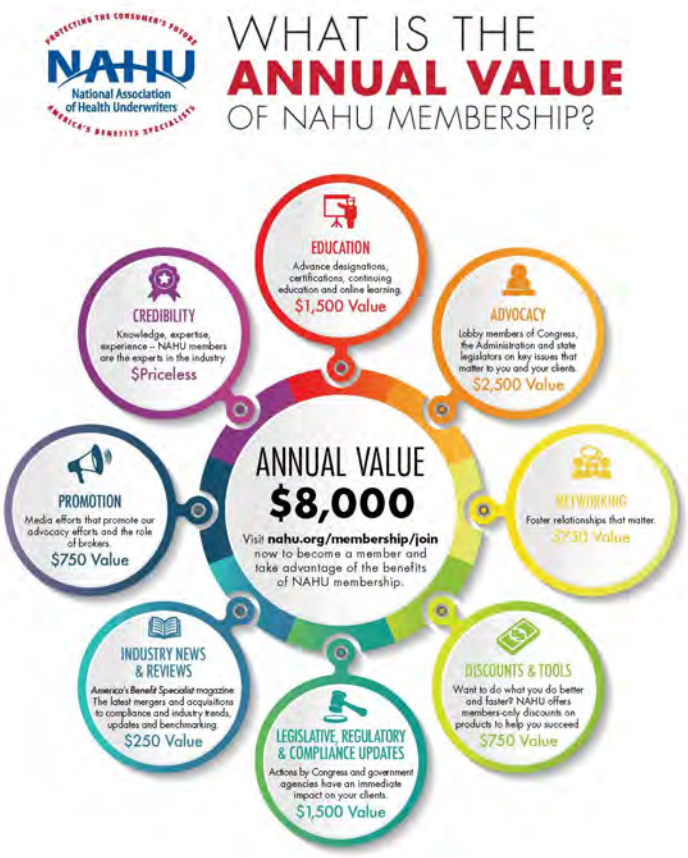

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