PROTECTING THE CONSUMER'S FUTURE
ORANGE COUNTY CAHIP
California Agents & Health Insurance Professionals
CALIFORNIA'S BENEFIT SPECIALISTS

C. O. I. N.

COUNTY OF ORANGE INSURANCE NEWS

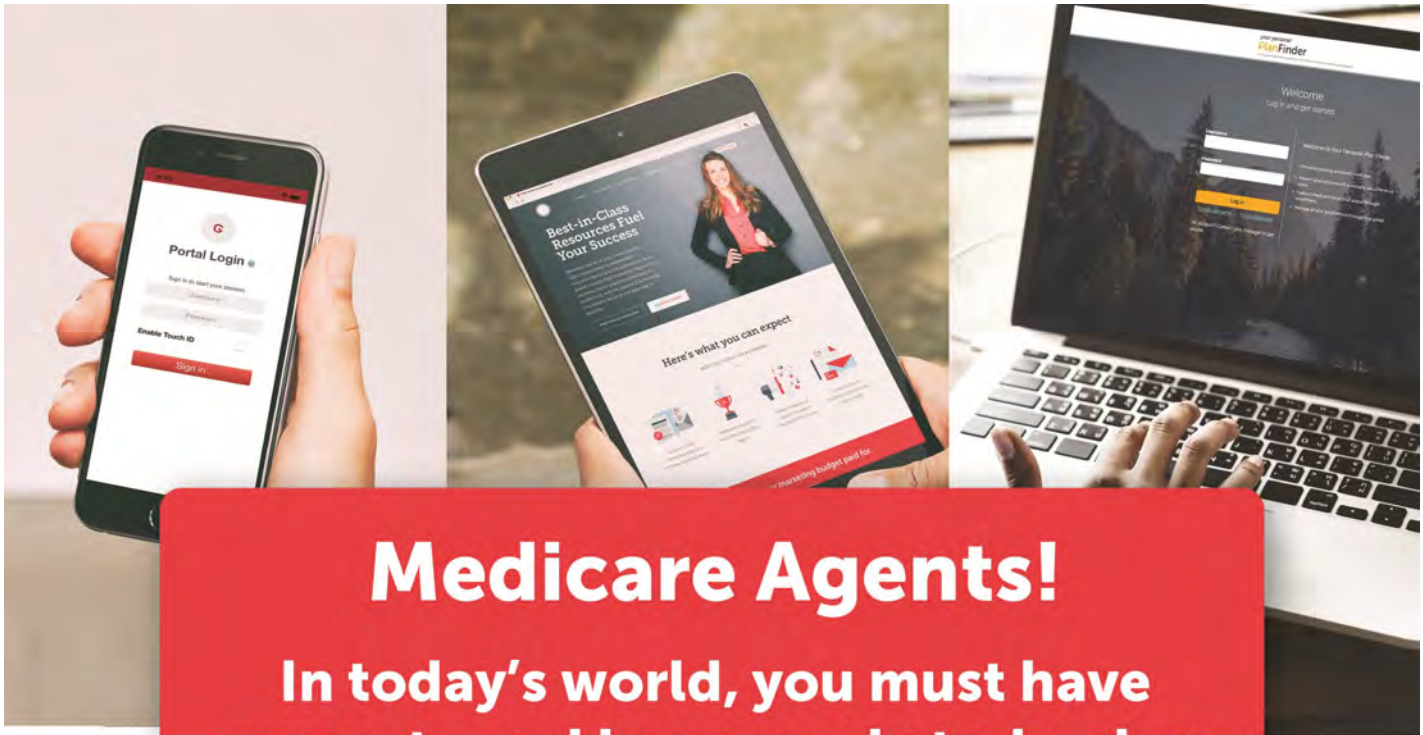
Volume 17, Issue 6
Nov/Dec 2022

Inside

THIS ISSUE:

National Association of Health Underwriters Gold Certified 2022

NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS 2022 PACESETTER AWARD



Medicare Agents!

In today's world, you must have access to and be properly trained on using remote enrollment tools.

AGA's Agent Portal gives you access to your own suite of online tools available anywhere you have the internet. It's a one-stop shop for all your Medicare business needs.

- Your Personal Plan Finder platform
- Quote ALL plans
- Enroll remotely
- Text SOAs

Call today!

1-844-SALES-UP

www.appliedga.com

aga

TABLE OF CONTENTS

Thank you for being a part of CAHIP-OC!

What's Inside

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 CAHIP-OC 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

It's the end of another year and almost the end of 4th Quarter. It's a great time to reflect on the past year.

It's the end of another year and almost the end of 4th Quarter. It's a great time to reflect on the past year.

We've accomplished a lot this year! Some of the highlights of 2022:

We had a great Sales Symposium in February with guest speaker Vince Ferragamo as the keynote speaker. It was great to be back with our colleagues.

We followed CAHU's lead and changed our name from OCAHU to CAHIP OC which better reflects what we do as insurance professionals.

Under the direction of Juan Lopez, we held another successful Golf Tournament benefitting Cystic Fibrosis in April.

Since we had the Women in Business event, we decided to have a scaled back version in June at the Lake Forest Community Center and exceeded our goal of raising money for New Hope.

OCAHU received several awards at the NAHU Convention in Austin TX. In fact, they won more than any other Chapter in NAHU! Great job, Sarah Knapp! In addition, CAHIP OC received several CAHIP awards including Large Chapter of the Year and Outstanding newsletter and Maggie, Dorothy and I received the Distinguished Service Award.

Our new Board was installed and began work on the 2022-23 agenda with a great deal of enthusiasm. Dorothy Cociu went into high gear with an impactful CE Day in September followed by an immensely informative Client Day in October and an Ethics course in November.

With the help of Maggie Stedt and her cochairs we held another extremely successful Medicare Summit. With a record number in attendance, we were inspired by the incomparable Dan Clark. In addition, because of the dedication of Gonzo, Brianna, John, Sarah, and Dave we got 35 new members to our amazing Chapter!

In November, CAHIP OC (OCAHU) was awarded the Outstanding Philanthropic Groups by the National Philanthropy Association of Orange County and the Orange County Business Journal.

Finally, we had an entertaining and inspirational holiday luncheon with keynote speaker Lisa Hutcherson.

I am so looking forward to what's ahead for 2023. There is so much more to come!

I would like to wish one and all very Happy Holidays and a healthy and prosperous 2023.

##

Feature Article:

Market Update: ACA Family Glitch Fix Final Rule Compliance Considerations

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

The Biden Administration released a final rule in October 2022, which closes the longstanding family glitch in the Affordable Care Act (ACA). The rule goes into effect on December 12, 2022, and it impacts Individual and Family Plan (IFP) coverage and employer-sponsored coverage effective in 2023.

ACA FAMILY GLITCH – BACKSTORY

The family glitch centers around employees' costs for spouse and/or dependent premiums on an employer-sponsored plan – and those spouses' and dependents' inabilities to obtain alternate subsidized IFP coverage on a state Exchange/Marketplace, utilizing Premium Tax Credits (PTCs).

Prior to the new "family glitch" fix rule, the ACA considered an employer-based offer of coverage to be affordable for an employee – and the employee's entire family – if the lowest-cost "employee-only" premium did not exceed a certain affordability threshold (and coverage was offered to spouses and dependents, at any cost). The affordability threshold is indexed at 9.5% annually. For plan years effective in 2023, it is 9.12%. For plan years effective in 2022, it is 9.61%.

Prior to the new rule, if the lowest-cost "employee-only" premium (after employer contribution) does not exceed 9.5% (as adjusted) of a person's pay (or the Federal Poverty Level), and Minimum Essential Coverage (MEC) of any cost is offered to spouses and dependents, then it is considered an affordable offer of coverage. When an affordable offer of coverage is made by the employer under these conditions, neither the employee nor the employee's spouse or children may obtain subsidized Individual and Family Plan (IFP) coverage using a PTC.

As a reminder, PTCs are only available to individual and family applicants obtaining individual coverage on a state Exchange/Marketplace, such as Covered California, Nevada Health Link, etc.

SUMMARY OF NEW "FAMILY GLITCH" FINAL RULE

The new rule changes this definition of "affordability." Going forward, spouses and dependents may now qualify for subsidized Individual and Family Plan (IFP) premiums using PTCs on a state Exchange – if only the employee's coverage is considered affordable (but the family coverage is not).

The state Exchanges/Marketplaces will now perform three affordability determinations:

1. The Exchange will determine if the applicant (employee) has been made an offer of affordable coverage by the employer (according to the "self-only" plan offered, if applicable).
2. The Exchange will evaluate the cost of the related individuals' premiums (spouse + dependents' premiums), based on the cost of family coverage offered by the employer.
3. The Exchange will evaluate the cost of related individuals' premiums who have alternate offers of group coverage, made by another employer (if available).

Employees would be barred from accessing PTCs on a state Exchange if the employer makes an offer of coverage that is affordable to the employee, based on the "employee-rate." However, if the cost to cover the family under the employer's plan is unaffordable, then the family members would qualify for a PTC (but not the employee).

The family glitch fix does not impact affordability tests or offers of coverage under the ACA's employer mandate whatsoever. Furthermore, at least for now, it does not require additional employer reporting.

IMPACTS ON THE INDIVIDUAL MARKET

The Biden administration estimates that approximately 5.1 million Americans are impacted by the family glitch, but it also estimates that only about 200,000 will gain subsidized Marketplace coverage under the new rule. The industry will have a better understanding of the fix's utility after the conclusion of the 2023 plan year, once all PTCs are claimed and utilized.

Such "family glitch" fix may bring some challenges to the group market. Dependent "children" are younger and often healthier than older adults. If these dependents (and spouses) forgo coverage in the group plan and obtain coverage in the Individual Market utilizing a PTC, then the group plans may face new adverse selection challenges. Group plans may be left with a disproportionate amount of less healthy adults, while the individual Exchange plans may gain an influx of younger, healthier participants. Conversely, the move of healthier individuals into the IFP market may bring down IFP costs for coverage obtained on an Exchange. The resulting impacts of such changes will likely not be realized until the end of the 2023 plan year, at the earliest.

Families considering leaving the group plan (for a subsidized IFP plan) may find the IFP premium to be more attractive – but may not consider other unexpected challenges connected with the coverage change. Group plans are traditionally richer and more robust than IFP-market plans, with stronger provider networks.

Furthermore, "split families" are a new issue. If the employee elects the affordable group plan, but family members

Continued on page 6

Legislative Updates:

By: David Benson - CAHIP-OC VP Legislation

ACA Reporting Deadline Extended by IRS Final Rule

The following article was posted on the NAHU website.

The IRS released a final rule this week permanently extending the deadline for ACA employer reporting by 30 days. This means that employers will have until 30 days after the initial deadline of January 31 to furnish these forms each plan year, effective immediately. For 2023, the deadline is now March 2.

Section 6055 and 6056 of the ACA reporting regulations require that employers furnish Forms 1095-B and/or Forms 1095-C to employees no later than January 31 of the year following the applicable calendar year. In other words, under the formal rules, forms for the 2021 calendar year need to be distributed by January 31, 2022. However, since 2015, the IRS has consistently extended this deadline, typically by 30 days. In 2020, the IRS requested comments about this extension while indicating that it would not continue to offer such relief for future filings. In response to various concerns commenters submitted about the reporting requirements, and contrary to the warning it issued in 2020, the IRS issued an automatic 30-day extension to the January 31 filing deadline in the proposed regulations.

NAHU submitted comments to the administration earlier this year; we noted our appreciation for a permanent, automatic extension, as the additional 30 days added to this delivery window is essential relief for many employers. It is particularly important for those that choose to utilize the Form W-2 affordability safe harbor, since those employers cannot complete their reporting processes until they have all wage data for the prior year fully calculated, which often does not happen until the first few weeks of the new year. We also urged the IRS to finalize this rule as soon as possible, considering the positive impact this permanent extension would have on the affected parties, in addition to urging the agency to communicate the deadline change to states that have imposed their own individual health insurance coverage mandates and related reporting requirements.

This final rule also eliminates good-faith transition relief. Since the ACA's reporting requirements first went into effect in 2015, the federal government instituted a good-faith policy, which has shielded employers from penalties for incorrect or incomplete ACA filings, provided that the employers have made a "good-faith effort" to comply with the requirements.

NAHU asked the IRS to reconsider this action, as this this transitional relief protects plan sponsors and issuers that accidentally include incorrect or incomplete information, including TINs or dates of birth, as part of their information returns or reporting statements. Unfortunately, the final regulation released this week eliminates this good-faith transition relief; with the absence of this transitional relief, employers are, more than ever, strongly encouraged to review their 2022 forms carefully to ensure accuracy as to avoid penalties.

##

ACA Family Glitch cont. from page 5

obtain alternate IFP-market plan ("splitting" from the employee's plan), then the plans will likely have different networks, deductibles, out-of-pocket (OOP) maximums, etc.

Consumer education in this area is critical, as individual consumers may focus on the cost of the premiums only – rather than other related areas such as networks, benefits, cost-sharing aggregation, etc. And, remember, if the spouse has a qualifying offer of coverage from an employer, then the spouse (and maybe the spouse's dependent children) is not eligible for subsidized IFP coverage utilizing a PTC.

IMPACTS ON THE EMPLOYER MARKET

While most impacts of the "family glitch" fix will not be realized until the end of the 2023 plan year, there are some preliminary concerns of which to be aware.

The first area of concern relates to carrier participation requirements. If carriers require a certain percentage of family members to be covered by a plan, there is a potential for some employer groups to fail to meet participation requirements – if enough spouses and dependents leave the employer-sponsored plans because of the new rule. Note that dependent participation requirements vary drastically among carriers, market segments, and states. Some carriers do not have dependent participation requirements at all.

Furthermore, if many spouses and dependents leave the group health market to obtain coverage in the IFP market, it is unclear how premiums may be impacted. However, increased premiums in the group market may be likely.

While the "family glitch" brings no employer reporting changes today, that may change in the future. The Internal Revenue Service (IRS) and U.S. Department of Health and Human Services (HHS) will likely need additional information to accurately process spouses and dependents who may now be eligible for PTCs, based on an employer's offer of coverage.

Continued on page 11

CAHIP Name Change

By: Jennifer Holmberg, MAOM, CEBS - CAHIP-OC VP of Communications & Public Affairs

California Health Insurance Agents Rename Their Professional Association

Association Rebrands as California Agents & Health Insurance Professionals (CAHIP)

The following press release was released on February 8, 2022

SACRAMENTO, Calif. (February 8, 2022) – The professional association representing California's professional health insurance agents has changed its name to California Agents & Health Insurance Professionals (CAHIP, pronounced CAY-hip). The association, made up of more than 1,600 members in 13 chapters, is the state's largest organization of professional health insurance professionals.

The organization, previously known as the California Association of Health Underwriters (CAHU), made the decision to rebrand after receiving feedback from members and lawmakers that its prior name was confusing. The management team of CAHIP, as well as the group's status under a national corporate structure, remains unchanged

"Our old name simply didn't reflect our role as an advocate for every Californian to get the right, personalized healthcare coverage for all stages in life," said Brad Davis, president of CAHIP. "The CAHIP name more accurately reflects our diverse membership and commitment to providing solutions for an individual's health, financial and retirement needs."

A recent survey found that 70% of CAHIP's members were favor of a new name and brand. They also shared that the word "underwriter" was an antiquated term often associated with denial of coverage and didn't fully represent the variety of services provided to clients. A unanimous vote by the organization's Board of Directors recently made the name change official.

"This is an exciting time for our organization to help residents in communities across the state access affordable care for the whole person, through medical, chiropractic, vision, mental health or dental insurance options," said Davis. "We can now re-focus on our ongoing efforts to provide world-class service to our members for years to come."

CAHIP, which was founded in the late 1980s, remains under the National Association of Health Underwriters (NAHU) umbrella. That organization represents more than 100,000 licensed health insurance agents, brokers, general agents, consultants and benefit professionals through more than 200 chapters across America.

About California Agents & Health Insurance Professionals (CAHIP)

##

Diving into the New Requirements of TiC, CAA No Surprises Act and CAA RX Benefit Reporting

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

Do you think it's ever going to get any easier to comply with all of the current regulations for employer-sponsored health plans? In a recent survey of my own employer clients, the answer was an astounding NO! Although I've prepared them for it for over 18 months, after first reporting it in late 2020, now that the deadlines have arrived or are about to, I watch their eyes glaze over when I do seminars and I ponder the no response when I ask the audience a question on several of these items.

All I can say to make you feel better is to remember what it was like when we first learned about the ACA rules. It seemed impossible then, but as time went on, it got easier, and you began to accept it and understand it.

Now, we're doing the same thing with the myriad of new regulations related to the Transparency in Coverage Shoppable Services Online Self-Service Tool, TiC Machine Readable Files, the CAA's No Surprises Act and the CAA RX Benefit Reporting. If it makes you feel any better, I promise you that by mid-2023, it will probably all fall into place, and your eyes will reflect knowledge instead of sheer nothingness or pure confusion. (At least, that is my hope!)

BACKGROUND INFORMATION

Where do I begin? How about at the beginning, since I've already mentioned the ACA. As required in the Affordable Care Act, the Transparency in Coverage final rules (TiC) were issued on November 12, 2020. Not long after, the Consolidated Appropriations Act (CAA) was signed into law on December 27, 2020, which included the "No Surprises Act" (Title 1 of Div. BB) and "Transparency" (Title II of Div. BB). On August 20, 2021, FAQs were issued (Part 49), which included new effective dates for some, but not all, of the TiC and CAA provisions.

The TiC final rule included requirements for Machine-Readable Files to be publicly disclosed, as well as an On-Line Self-Service Tool. The Machine-Readable File public disclosures is defined as a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine readable files (MRFs) include, but are not limited to .XML, .JSON and .CVS formats. As the title illudes to, MRFs are not intended for the layperson, such as an employer's plan participants, to read. They of course can, as they are publicly posted, but they focus instead on being available for MACHINES, or computer systems, to understand and decipher, and to use to provide overall data for future public disclosure in many forms. The data allows computer programs and systems to break it down and study the data for multiple disclosure purposes.

These laws have been considered among the most confusing and most difficult for our employer clients, so I wanted to write a detailed article (of course!) to break it all down for each of you. Even Marilyn Monahan, our benefits and insurance attorney, thinks it's been confusing for employers. "Part of the good news here is that we do have more guidance available to us now, on both the TiC MRFs and the RX reporting," stated Marilyn.

TiC REQUIREMENTS FOR MRFS

The TiC requires plans and insurance issuers to publicly post two machine-readable files: a) In-Network Provider Rates for Covered Items and Services, and b) Out-of-Network (OON) Allowed Amounts for Covered Items and Services. For in-network items and services, the MRF must list, for each coverage option, negotiated rates for all covered items or services between the plan or issuer and the in-network providers. The Out-of-Network second MRF must show, for each coverage option, both the historical payments to and the billed charges from out-of-network providers. This list will include the unique OON allowed amounts and billed charges for covered items and services furnished by OON providers during the 90-day period that begins 180 days prior to the publication date of the MRF. Historical payments for a particular item or service and provider under a single plan or coverage must have a minimum of 20 entries or data is omitted to protect consumer privacy.

These first two MRFs were done to be posted by July 1, 2022 for plan years on or after January 1, 2022, by July 1, 2022, so all renewal dates January through July had to be posted by July 1, 2022, and for each renewal date after July 1, they were required to be posted by that renewal date (i.e. August 1 renewals by August 1, 2022, September 1 renewals by September 1, 2022, and so forth).

"The responsibility of the employer," stated Marilyn Monahan, "is to make certain that the third parties that it works with will populate and post these MRFs."

There was a requirement for a MRF for Covered Prescription Drug prices, but that requirement was delayed indefinitely because of the CAA's RX Reporting requirements, which I'll talk about later in this article. They felt the TiC provisions would be duplicative of much of the CAA requirements.

Those first two MRFs are required to be publicly available and accessible to any person, free of charge, and without conditions, such as establishment of a user account, password or other credentials, or submission of any personally identifiable information to access the file… So, in other words, it must be publicly posted for anyone who wishes to see the data by simply clicking on the data links. The files must be updated monthly, and clearly indicate the date of the update.

It is important to note that the MRF provision of the TiC does

Continued on page 9

New Requirements of TiC cont. from page 8

NOT apply to grandfathered health plans under the ACA, and also does not apply to excepted benefits, such as limited-scope dental and vision plans, or account-based group health plans, such as HRAs or Health FSAs.

The MRFs are not required to be user friendly. The federal Departments expect the data to be used by aggregators and researchers, who will apply the data to many future statistical and public disclosure reporting analytics.

Additional disclosures may include "data dictionaries," disclaimers and clarifications, such as explaining why the cost of care may vary from hospital to hospital or region to region. Some health insurance carriers have been adding language about the size and the use of the files as well.

REQUIRED WRITTEN AGREEMENT APPLIES TO FULLY INSURED AND SELF-FUNDED HEALTH PLANS

One important requirement to be aware of is that all Plan Sponsor Employers, whether you are fully insured or self-funded, are required to enter into a written agreement with the vendors providing them with the data, as well as posting the MRFs and links.

For **fully insured** health plans, the plan will satisfy the MRF mandate if the plan requires the health plan insurance issuer offering the coverage (ie your insurance carrier) to provide the information pursuant to a written agreement. Then, if the issuer fails to provide the information, "the issuer, but not the plan, violates the transparency disclosure requirements."

For **self-funded** health plans, the plan may satisfy the MRF mandate if the plan enters into a written agreement under which another party (such as a third-party administrator, a health care claims clearing house, or Administrative Services Only -ASO- entity will provide the information. However, if the third-party fails to provide the information, "the plan…violates the transparency disclosure requirements." The form of the agreement is not defined, but it's vitally important, particularly to self-funded health plans, that they review the full agreement to ensure it provides the protections of the plan and the employer needs, as well as transfers the liability to the third-party vendor who will be providing the data.

The written agreement provisions were recently verified with Marilyn Monahan. "The other main requirement for employers, whether fully insured or self-funded, is the written agreement," stated Marilyn. "Employers don't have access to the in-network pricing or the OON prices. Even if you're self-funded, the employer itself doesn't typically have that data. However, its TPA has it, its ASO has it, and so forth. So, if you are self-funded, you are relying on these third parties to compile and post the data. Similarly, if you have a fully insured plan, only the carrier—and not the employer—will have this data. Therefore, you're relying either on your insurance carrier or your TPA or ASO to take care of this. But what the employer has to do, under the rules, is to have a written agreement in place with that third party, through which that third party agrees to be responsible. That is a requirement whether your plan is fully insured or self-funded. And what's unusual here is that the mandate to have a written agreement is actually written into the regulations, and not only for self-funded plans, but it's written into the regulations for fully insured plans also."

Our main concern is of course employer/plan sponsor liability if you don't have the written agreements in place. "If you don't have a written agreement," affirmed Marilyn, "and the carrier fails to perform, then the employer could be liable."

Note that this requirement is not part of your HIPAA Business Associates Agreement, as BA agreements only include protections related to HIPAA Privacy & Security, and no other requirements. Your standard administrative agreement will need to be amended, or a separate written agreement will need to be entered into.

POSTING MRFs

Recent guidance has clarified some of the questions we had related to who posts the data and links to the post. The MRFs must be posted on a public website, but they may be posted by a third-party, such as the issuer or TPA, on behalf of the plan.

Updated guidance states that a distinction is drawn between the employer and the employer's group health plan. A third party (like an issuer or TPA) may post the data on its public "website for the plan," if there is a written agreement, but if the employer's group health plan does not have its own website, the "plan" does not have to create its own website, either to post the files or provide a link. If the "plan" maintains a public website, the plan must post a link to the aggregated "Allowable Amounts" file posted by the third party. The "employer's" public website does not have to post the data or a link. This could potentially be different than what some interpreted prior to recent guidance.

Another important point for employers to understand is that it's ongoing. "By the way" stated Marilyn, "this requirement is not going away. The MRFs have to be updated on a regular basis, and if you get a new carrier in the future, or you enter into a new relationship with a new TPA, this should be part of your discussion process."

TiC FINAL RULE- ONLINE SELF-SERVICE TOOL FOR SHOPPABLE SERVICES

We've been hearing about the Online Self-Service Tool for shoppable services for about two years now… So what does it require and what is its intent?

Marilyn discussed the intent with us in our November 9th webinar. "For the first time, most consumers will be able to get real-time and accurate estimates of their cost-sharing liability for health care items and services from different providers in real time, allowing them to both understand how costs for covered health care items and services are determined by their plan, and also shop and compare health care cost before receiving care."

The Online Self-Service Tool under the TiC final rule requires plans and issuers, although not grandfathered plans (but see below as the CAA does require similar provisions for grandfa-

Continued on page 12

COIN COMPLIANCE CORNER

What Agents and Your Clients Need to Know!

HIPAA Privacy & Security Enforcement Updates -

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

I have just a couple of items to share with you in this issue.

HHS Office for Civil Rights Issues Bulletin on Requirements under HIPAA for Online Tracking Technologies to Protect the Privacy and Security of Health Information

On December 1, 2022, the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services issued a bulletin to highlight the obligations of Health Insurance Portability and Accountability Act of 1996 (HIPAA) on covered entities and business associates ("regulated entities") under the HIPAA Privacy, Security, and Breach Notification Rules ("HIPAA Rules") when using online tracking technologies. These online tracking technologies, like Google Analytics or Meta Pixel, collect and analyze information about how internet users are interacting with a regulated entity's website or mobile application.

Some regulated entities regularly share electronic protected health information (ePHI) with online tracking technology vendors and some may be doing so in a manner that violates the HIPAA Rules. The HIPAA Rules apply when the information that regulated entities collect through tracking technologies or disclose to tracking technology vendors includes ePHI. Regulated entities are not permitted to use tracking technologies in a manner that would result in impermissible disclosures of ePHI to tracking technology vendors or any other violations of the HIPAA Rules.

The HHS/OCR bulletin addresses potential impermissible disclosures of ePHI by HIPAA regulated entities to online technology tracking vendors. The Bulletin explains what tracking technologies are, how they are used, and what steps regulated entities must take to protect ePHI when using tracking technologies to comply with the HIPAA Rules. Specifically, the Bulletin provides insight and examples of:

- Tracking on webpages
- Tracking within mobile apps
- HIPAA compliance obligations for regulated entities when using tracking technologies

"Providers, health plans, and HIPAA-regulated entities, including technology platforms, must follow the law. This means considering the risks to patients' health information when using tracking technologies," said OCR Director Melanie Fontes Rainer. "Our Bulletin answers questions for those using tracking technologies, importantly how to protect the privacy and security of the health information they hold."

Read the Bulletin here: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-online-tracking/index.html

Data Breach – Connexin Software

Although not an HHS/OCR reported data breach, Lifelock reported on December 5, 2022 that Connexin Software, Inc. had a data breach impacting 2.2 million patients and 119 pediatric practices.

Connexin Sofware is a provider of electronic medial records and software for pediatric groups. They reported that a data breach occurred in August, 2022, possibly including patient names, guarantor name, parent/guardian names, addresses, email address, dates of birth, social security numbers, health insurance information, medical and/or treatment information, as well as billing and/or claims information. Much of this information can be used, if exploited, to commit identity theft. Obviously this breach will also be of interest to HHS/OCR once they receive an official breach report.

It's likely that an OCR investigation will occur upon receipt of the breach report. I'm sure we'll be hearing more about this breach from HHS/OCR in the weeks and months to come.

##

ACA Family Glitch, cont. from page 6

NO CHANGES TO ACA EMPLOYER MANDATE

The "family glitch" final rule does not impact the ACA's employer mandate whatsoever. Under the employer mandate, Applicable Large Employers (ALEs) must offer affordable health insurance coverage — that provides Minimum Value (pays at least 60% of benefits) and is at least Minimum Essential Coverage (MEC) — to all Full Time (FT) employees. ALEs must also offer at least MEC (at any cost) to FT employees' dependent children up to age 26. The employer mandate does not require the ALE to offer coverage to spouses.

The National Association of Health Underwriters (NAHU) is pushing support of two federal bills that would allow ALEs the option of reporting offers of ACA-compliant coverage prospectively, instead of retrospectively (current process). This would help consumers understand their eligibilities for PTCs when enrolling in the plan, rather than at the end of the plan year.

PERMISSIBLE SECTION 125 CHANGES

The "family glitch" final rule allows employers to amend their pre-tax Section 125 ("Premium Only Plan" – POP) rules, so employees' dependents can take advantage of new PTCs. Normal IRS rules prohibit employees from changing their elections midyear, when funding premiums with pre-tax dollars (exception: qualifying life events).

Employers may voluntarily amend their Section 125 Cafeteria Plans to permit eligible dependents to drop their group coverage midyear, in favor of subsidized individual Exchange coverage. This allows employees' spouses and dependents to enroll in IFP Exchange coverage effective 1/1 during the current Open Enrollment Period.

Employers are not required to allow these election changes. However, if they wish to permit such changes, they must inform employees of their rights to make a change in accordance with the new rule and adopt a formal plan amendment on/before the last day of the plan year in which the election changes are allowed. Consultation with an ERISA attorney or tax counsel is highly advised, to ensure full compliance with the law according to the employer's own specific circumstances.

TIMELINE

The final rule was published on October 13, 2022, and goes into effect December 12, 2022. The individual Exchange Open Enrollment period begins November 1, 2022, for coverage that is effective January 1, 2023.

Exchange IFP coverage applicants may utilize the new "family glitch fix" PTCs when enrolling in coverage now, for coverage that is effective January 1, 2023, and later.

##

thered plans), to make available to participants personalized out-of-pocket cost information, and the underlying negotiated rate, for all covered health care items and services, including prescription drugs, through both an internet-based self-service tool and in paper form upon request (note also that the CAA also adds a telephone requirement – below).

What has to be disclosed is an initial list of 500 "shoppable" items or services, as identified by the Departments (see my prior articles for more information on this) must be available for plan years beginning on or after January 1, 2023.

A shoppable service is one that can be scheduled in advance, and typically is provided in non-urgent situations, thus allowing patients to price shop and schedule the service when it's convenient for them, at the most affordable rates. The 500 shoppable services are defined; all entities are required to post the same items and services, for easy comparisons for consumers.

All other items or services must be available for plan years beginning on or after January 1, 2024.

CAA PRICE COMPARISON TOOL

The CAA Price Comparison Tool is "largely duplicative" of the TiC self-service tool, but it also applies to grandfathered plans (grandfathered under the ACA) and includes a requirement to provide the information as required above by the TiC, but also a requirement to provide information over the phone. The implementation date of the CAA Price Comparison tool was delayed until January 1, 2023, to be consistent with the TiC self-service tool requirements.

To be specific and to clarify, grandfathered plans under the ACA are only exempt from the MRF posting requirements; they are NOT exempt from the price comparison/TiC online self-service tool. Grandfathered health plans under the ACA are not exempt from the online self-service tool requirements.

We highly recommend that employers consider employee and plan participant communications about the price comparison/online self-service tool so that they understand that they can start fully shopping their non-emergency services for cost containment.

CAA PRICE COMPARISON TOOL WRITTEN AGREEMENT REQUIREMENT FOR EMPLOYER PLAN SPONSORS

The CAA Price Comparison Tool also requires a written agreement with your health plan issuer/carrier.

For **fully insured** plans, you must enter into a written agreement with your issuer.

For **self-funded** plans, you must either comply or outsource this task to a TPA or ASO vendor. If the self-funded employer outsources it (most will need to as they don't have access to the information required), they should enter into a written agreement, and consider adding it to the SPD for plan participant information.

Like the TiC written agreement requirements, the self-funded health plan still remains liable, but they should enter into an agreement that ensures that the third party will provide the data and post the requirements and provide appropriate protections for the health plan and employer.

CAA NO SURPRISES ACT BACKGROUND

Because I have written several articles on the No Surprises Act I will not get into a tremendous amount of detail on this topic, but I will highlight the most important provisions and recent developments.

The No Surprises Act is intended to prevent balance billings in certain circumstances. These provisions are applicable to health plans and health plan issuers (ie carriers) for major medical coverage. They do not apply, however, to stand-alone dental or vision plans.

Under the No Surprises Act (NSA), emergency services must be treated on an in-network basis without prior authorization, regardless of where they are provided. The NSA modified the requirements for Emergency Services to include a "prudent layperson" standard to determine what is or is not an emergency. The NSA also bans out-of-network cost sharing for non-emergency services at an in-network facility. Under the NSA, non-emergency services require a standard for determining cost-sharing amounts (typically, the lesser of the billed charge and the "qualifying payment amount" or QPA. It's important to note that in some circumstances, a patient can consent, with advance notice, to pay an Out-of-Network (OON) rate, subject to the NSA rules.

Similar to the CAA Pharmacy Reporting disclosures (which I'll discuss next), the NSA requires 2022 plan data to be reported by March 31, 2023, and 2023 data to be reported March 31, 2024. Under the Air Ambulance provisions of the CAA, fully insured and self-funded employers will need contracts in place with a carrier or TPA to provide these services. Self-funded plans retain the liability, the same as other provisions of the TiC and CAA discussed in this article.

EMERGENCY MEDICAL CONDITION

The NSA changed the definition of an emergency medical condition, to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to: 1) place their health in serious jeopardy ; 2) seriously impair bodily functions, or 3) cause serious disfunction to a bodily organ or part.

Plans must ultimately determine whether the standard was met by reviewing presenting symptoms, without imposing any type of time limit between onset and presentation for emergency care.

Of course, the NSA made changes to requirements for ID cards, with new language requirements, provider directories and more.

Most importantly, the NSA required a new No Surprises Act Notice, which incidentally, was modified mid-year 2022. If you used the model notice issued just prior to January 1, 2022, note that you will need to use the new notice issued this past summer with your next renewal. The old notice will suffice

Continued on page 13

New Requirements of TiC cont. from page 12

throughout 2022. These notices must be customized for each employer, and if fully insured, you must include any state law provisions on balance billing that apply in your state (or multiple states). Self-funded plans following ERISA rules need only include the federal information on surprise billing protections in the notices.

A notice of patient protections was also implemented with the NSA. Providers must notify patients if they intend to charge more than the network rate, and the patient must agree to the additional charges in writing. My personal fear has been and continues to be that providers will bury the authorization with other paperwork that the patient must sign, and the patient will unknowingly give up his or her rights under the NSA.

The surprise billing rules also require plans or issuers to provide an advance EOB to estimate charges for upcoming services. There are several other provisions also included in the No Surprises Act, including the creation of a federal portal for claims disputes, which must be submitted into the Independent Dispute Resolution Process (IDR), which I have written previous articles on.

QUALIFIED PAYMENT AMOUNT

The Qualified Payment Amount, or QPA, is the median of the in-network rate in a geographic area. If there is no network, such as in an Reference-Based Pricing plan (RBP), it becomes more complicated. In a fully insured plan, your carrier will deal with the QPA and the IDR. In a self-funded plan, the plan sponsor, third party administrator or ASO vendor will be directly involved.

Under the NSA, if a self-funded health plan and an out-of-network provider cannot agree on a payment rate, they must go through the new Independent Dispute Resolution Process. The Interim Final Rule states the contracted rates between providers and the network provider for the health plan would be treated as the self-insured plan's contracted rates for purposes of calculating the QPA.

A median contract rate should be determined by taking into account every group health plan offered by the self-insured plan sponsor. The Interim Final Rule (IFR) allows for administrative simplicity for self-funded plans to permit the TPA who processes their claims to determine the QPA for the plan sponsor by calculating the median contract rate based on all of the plans that it processes and administers claims for. The IFR states that the contracted rates between providers and the network provider for the health plan would be treated as the self-insured plan's contracted rates for purposes of calculating the QPA.

CAA RX REPORTING REQUIREMENTS

Whether you are fully insured or self-funded, you have responsibilities for compliance with the CAA Pharmacy Reporting rules. Section 204 of Title II of Division BB of the CAA added parallel provisions at section 9825 of the Internal Revenue Code (the Code), section 725 of the Employee Retirement Income Security Act (ERISA), and section 2799A–10 of the Public Health Service Act (PHS Act). The law requires group health plans and health insurance issuers offering group or individual health insurance coverage to annually submit to the Departments certain information about prescription drug and health care spending. Reports are submitted to CMS, and CMS will then publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs.

The goal is to provide valuable information about competition and market concentration in the pharmaceutical and health care industries. Policymakers can use the prescription drug and health care spending data to make informed decisions, including identifying any excessive pricing of prescription drugs driven by industry concentration and monopolistic behaviors, promoting the use of lower-cost generic drugs, and addressing the impact of pharmaceutical manufacturer rebates, fees, and other remuneration on prescription drug prices and on plan, issuer, and consumer costs.

REPORTING DEADLINES

This mandate will require that plans/issuers report for **2020** and **2021** calendar years by December 27, 2022, and annually thereafter on **June 1**:

- The 50 brand prescription drugs most frequently dispensed by pharmacies;
- The 50 most costly prescription drugs; and

Continued on page 17

CAHIP-OC Board of Directors and Staff 2022-2023

Contact Information

EXECUTIVE BOARD

PRESIDENT/PUBLIC SERVICE
Patricia Stiffler, LPRT
Options in Insurance
Tel: (714) 695-0674
keystonepatty@aol.com

PRESIDENT-ELECT
John Evangelista, LPRT
Colonial Life
Tel: (949) 452-9206
John.evangelista@coloniallifesales.com

IMMEDIATE PAST-PRESIDENT
HUB
Tel: (720) 989-4950
joann.vernon@hubinternational.com

VP of COMMUNICATIONS & PUBLIC AFFAIRS
Jennifer Holmberg, MAOM, CEBS
Risk Strategies
Tel: (714) 325-1170
jholmberg@risk-strategies.com

VP of FINANCE/SECRETARY GOLF CHAIR
Juan Lopez
Colonial Life / AGA
Tel: (714) 357-0600
juan.lopez1@me.com

VP of LEGISLATION
David Benson, LUTCF
DCB Insurance Services
Tel: (949) 328-9110
david@dcbins.com

VP of MEMBERSHIP
Gonzalo Verduzco
Word & Brown
Tel: (714) 345-2558
gverduzco@wordandbrown.com

VP of POLITICAL ACTION
John Austin
CHOICE Administrators
Tel: (714) 542-4200
jaustin@choiceadmin.com

VP of PROFESSIONAL DEVELOPMENT
Dorothy Cociu, RHU, REBC
Advanced Benefit Consulting
Tel: (714) 693-9754
dmcociu@advancedbenefitconsulting.com

EXECUTIVE DIRECTOR
Gail James Clarke
Gail James Association Mgmt.
Tel: (714) 441-8951, ext. 3
orangecountyahu@yahoo.com

GENERAL BOARD MEMBERS

AWARD/HISTORIAN
Sarah Knapp
Colonial Life
Tel: (949) 463-8383
sarah.knapp@coloniallifesales.com

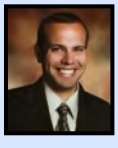
MEMBER RETENTION
Briana Hudson
Dickerson Insurance Services
Tel: (714) 451-5772
briana@dickerson-group.com

SPONSORSHIP
Louis Valladares
Applied General Agency
Tel: (714) 348-0255
lvalladares@appliedga.com

SENIOR SUMMIT CHAIR
Maggie Stedt, CSA, LPRT
Stedt Insurance Services
Tel: (949) 492-8234
mstedt@stedtinsurance.com

VANGUARD
David P.B. Ethington
Integrity Advisors
Tel: (714) 664-0605
david@integrity-advisors.com

SOCIAL MEDIA
Adriana Mendieta
Colonial Life / Zeguro
Tel: (562) 404-0672
adriana@mendieta.net



DIVERSITY & INCLUSION
Eric Terrazas
Colonial Life
eterrazas@coloniallifesales.com

Why Get Involved in CAHIP-OC?

- *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 - CAHIP-OC VP Membership

What do you get for your investment as a California Agents & Health Insurance Professionals, Orange County (CAHIP-OC) 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

CAHIP Orange County provides a rich forum for sharing ideas, asking questions and learning new technologies. You can make new connections with brokers, agents, carriers and vendors.

AND IT DOESN'T STOP THERE!

- National Association of Health Underwriters (NAHU) and California Agents & Health Insurance Professionals (CAHIP) will protect your right to serve your clients needs.
- The opportunity to make an impact on our industry by getting involved in legislative efforts both National and statewide.
- 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 CAHIP-OC!

Jeffrey Adams

Ryan Whittaker

Kasey Herbison

Amber Wu

Interested in Joining? Many ways to join:

- **Contact our Membership Team:**

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

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

- **Talk to a Member** *(see page 14 for board roster)*
- **Visit our website at www.ocahu.org**
- **Use our QR code**

JOIN CAHIP-OC

YOU AREN'T ALONE YOU HAVE NAHU!

NAHU
National Association of Health Underwriters

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

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

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

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

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

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

Become a member today at nahu.org/membership!

- The 50 prescription drugs with the greatest increase in plan expenditures

In addition, plans/issuers must report total spending; spending on prescription drugs by the plan as well as by participants/beneficiaries; and the average monthly premiums paid by participants/beneficiaries and by employers on behalf of participants/beneficiaries. Plans/issuers must report rebates, fees, and any other remuneration paid by drug manufacturers for each reporting period. For subsequent years, entities must report for 2022 calendar year by **June 1, 2023**, and then must report for each calendar year thereafter by following **June 1**.

APPLICABILITY

What health plans and issuers are required to submit include the following: Fully-insured and self-funded **group** health plans, including Health insurance issuers offering **group** coverage, Non-federal governmental plans, such as plans sponsored by state and local government, Church plans that are subject to the Internal Revenue Code, and Federal Employees Health Benefits (FEHB) plans. Health insurance issuers offering individual market coverage include : a) Student health plans; b) Plans sold through the Exchanges; c) Plans sold outside of the Exchanges; and d) Individual coverage issued through an association.

Plans or coverage NOT required to submit includes the following: a) Account-based plans, such as health reimbursement arrangements; b) Excepted benefits including but not limited to: Short-term limited-duration insurance, Hospital or other fixed indemnity insurance, Disease-specific insurance; c) Medicare Advantage and Part D plans; d) Medicaid plans; e) State children's health insurance program plans; f) Basic Health Program plans.

WHO, WHAT, WHERE TO SUBMIT?

First, it's important to note that multiple parties will likely be involved in submitting data, and CMS is set up to receive data from multiple parties for each health plan. If you're fully insured, your carrier will likely submit most if not all of the information (but keep reading because employer plan sponsors still have action items they must complete), but some may require employers to submit on their own or through other vendors some of the plan-level data, which I'll discuss below. Keep an eye out for emails or letters or notices on billings of items related to the CAA Pharmacy Reporting requirements from carriers, as they will vary greatly.

"Much of this data about prescription drugs will be in the hands of the PBM," stated Marilyn. "For example, they will know the 50 brand Rx drugs most frequently dispensed, but there is other data, like the total spending on health care, that is probably not going to be known by the PBM; it's going to be known by your TPA. Also, the PBM will not know the premium cost for the plan, but either the TPA or the employer will. These are perfect examples of how the parties need to work together to get the information to the powers that be in a timely manner."

SELF-FUNDED PLANS

If you're self-funded, it's likely that several parties will submit data, including your TPA or ASO provider, your Pharmacy Benefit Manager (PBM), or others, such as your broker (for example, ABC has set up an account and will be working with employer clients and TPAs to gather and submit portions of the data), as Marilyn mentioned previously. Also, keep in mind that some plans may have more than one PBM in multiple states or if special needs exist for multiple PBMs.

So how do you submit data? CMS has an online Enterprise Portal and RX Data Collection using their Health Insurance Oversight System (HIOS). There is a multifactor authentication and Identity Management System within the portal for security. Multiple outside vendors may submit data into the portal (again, which will likely include, at a minimum, your TPA and your PBM).

The portal is not easy, and not fast. You need to plan ahead, register well in advance as it takes time to be approved to be an eligible party to submit data into the portal for another entity, and then be prepared to submit data later. The portal and submission process has employers, administrators and PBMs scratching their heads and wondering how to learn and become efficient with this system.

"I do agree [it's a difficult process] but there are a couple of pointers I'd like to give you," stated Marilyn. "If you decide to register on your own and not use a third party for part of the process, I'd like to remind people that this is not like filing your taxes with Tax Cut. It's going to take a bit of time. If you've done it before, like ABC has, it's going to be easier than if you've never done it before, but it is going to take a little bit of time, like it takes time to register and file with the IRS your 1094 and 1095 forms. Don't wait until noon on December 27th to register. You can register early, even if the forms and data aren't ready to file, so you'll have that part of the process out of the way."

FULLY INSURED PLANS

Again, if your plan is fully insured, your carrier will do most of the reporting, but it is your responsibility as an employer plan sponsor to 1) have a written agreement with them that specifies that they will perform the duties related to the pharmacy reporting requirements and 2) watch for updates from emails, letters, notes on billings, etc. from your carrier, as one of these may have information related to these requirements, and you may receive a notice of a contract change or other, stating that they will do these things on your behalf. To be safe, we are sending written agreements on our fully insured clients' behalf to all of our clients' carriers, so that we can have documented correspondence with them. Some may not accept these agreements (as they have thousands of plan sponsors and may not want to have individual agreements), but if/when they respond, we can capture their responses for our clients' files. Again, carriers may simply just send plan sponsors a contract change by email or mail. It is the plan sponsor's responsibility to keep that in their contract file.

Continued on page 19

It's a great opportunity and there is no better time to connect with agents and other health insurance professionals than at CAHIP-Orange County's Sales Symposium. We have an exciting program to help our members grow. Please join us on February 9th in Fullerton!

New Requirements of TiC cont. from page 17

WHAT DATA IS REPORTED?

In summary, for fully insured employers, group health plan data will typically be reported by the issuer (as the "reporting entity")—but the issuer will typically need certain "plan-level" data from the employer. For self-funded employers, group health plan data will typically be reported by one or more third party vendors (such as a TPA, PBM, ASO)—but these "reporting entities" will need certain "plan-level" data from the employer. When the data is filed by the issuer or TPA, plan-level data for each plan is included (P2), along with "aggregated" data for the issuer or TPA's book of business (but broken down by market segment and state) (D1-D8). Note that data is reported on a calendar year, or "reference year" basis.

For both fully insured and self-funded plans, employer must have a contract/written agreement with the reporting entity or entities.

The employer plan sponsor may be in possession of some items that your carrier or issuer, or if self-funded, your TPA or ASO provider simply won't have. This is called "Plan-Level Data." The specific plan file that you may hear of is the P2 Data File, which may or may not be known by other parties, and includes: Identifying information such as plan name; plan number(s); plan sponsor; plan sponsor EIN; and issuer, TPA, and PBM names and EINs; Beginning and end dates of the plan year that ended on/before the last day of the reference year; the number of participants and beneficiaries ("members") covered on the **last day of reference year**; and each state in which the plan or coverage is offered.

There are also items needed from the employer health plan that needs to be submitted with the aggregated data; the D-1 file in particular. The D-1 file includes premium **amounts, including**: the average monthly premium amount paid by employers and other plan sponsors on behalf of participants and beneficiaries (ie the carrier may have the total premium collected, but they may not have the split between what is paid by the employer and what is paid by the plan participants in employee contributions to the plan); the average monthly premium amount paid by participants and beneficiaries; and the total annual premium amount and the total number of **life-years**. The **Life-Years** are the total number of members covered on a given day of each month of the reference year, divided by 12. Be advised that for premium data, enforcement relief was offered for 2020 and 2021 reference years.

So, again in summary, the information that outside parties may not have but will need from employers includes all or part of what is needed for the P1 and D1 information, whether you are fully insured or self-funded.

THE PHARMACY BENEFIT REPORTING WRITTEN AGREEMENT

Just like the TiC MRF requirements, the CAA Pharmacy Benefit reporting requirements have a requirement for a written agreement.

"That written agreement mandate, that same structure that applies to the MRFs, also applies to the prescription drug reporting requirement," stated Marilyn. "Whether you're fully insured or self-funded, you can outsource this to your insurance company, your TPA, your ASO, or your PBM, but you have to have a written agreement in place."

To summarize the action items and to provide a conclusion, the most important thing for an employer to do is get a written agreement in place with your vendors as soon as possible, to identify who is doing what, and to get your vendors to commit to complying by the due dates.

ACTION ITEMS FOR EMPLOYERS:

For All Plans: Be sure to calendar compliance dates. The initial RX reporting date is December 27, 2022 and annual dates for 2022 and after calendar years will be June 1 after the calendar year ends. For Fully Insured plans: Enter into a written agreement with issuer; timely provide any plan-level or other data required by issuer. For Self-Funded plans: Self-funded plans must either comply or outsource to a TPA or ASO; if you're outsourcing, you need to enter into a written agreement to assure that they timely provide any plan-level or other data required by the third party. You need the written agreements to lessen employer liability, period.

It is important to note that the written agreement requirement also applies to the TiC Final Rule (both MRF and on-line self-service tool mandates) and the CAA air ambulance reporting requirement. Our ABC contracts include all of these items and allows us to customize for each client and delete unneeded items in each circumstance.

You may have already been receiving some emails or other correspondence from your carriers, administrators or PBMs on this. Do not ignore them. Our clients have of course already been informed on the role we will play in this to assist them through the entire process.

I hope your eyes will indeed reflect knowledge and understanding on these topics in the months to come…. Best of luck with it all, and happy reporting!

##

2nd Annual Cornhole Tournament Photos

National Philanthropy Day

Congratulations Pat Stiffler & CAHIP-OC!

Consumer Education Day Photos

CAHIP Podcast Series

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

Latest Podcasts:

- **Medicare Updates for 2023**
- **How Close Did We Come to Single Payer Healthcare in California?**
- **CAA's No Surprises Act**

Subscribe to NAHU's Healthcare Happy Hour

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

Latest Podcasts:

- **HRA Council Releases 2022 Report on ICHRA and QSEHRA Trends**
- **Bill Introduced to Exclude Agents/Brokers from Medicare Marketing Requirements**
- **National Long-Term Care Awareness Month**
- **2022 Midterm Election Review**

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.

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

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.

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

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.

JOIN CAHIP-OC

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.

- Give Employees the Gift of Healthy Pets
- 12 Ways to Say Thank You
- 7 ways to Improve Employees' Financial Wellness
- Benefits 101: Life Insurance Basics

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

Follow CAHIP-OC on Social Media!

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

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

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

Are you contributing to CAHU-PAC?

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

To start contributing copy the form on page 25 of this issue and mail to CAHU today or simply use the QR code!

Thanks for your participation!

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

CAHU PAC CONTRIBUTOR COMMITMENT FORM

LAST NAME FIRST NAME MIDDLE

OCCUPATION (Required for FPPC reporting purposes)

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

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

CITY, STATE, ZIP PHONE FAX

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

CITY, STATE, ZIP PHONE FAX

CONTACT EMAIL ADDRESS LOCAL CHAPTER

PRECIOUS GEM STONE CONTRIBUTION LEVELS

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

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

PAYMENT METHOD: (attach check or select method below)

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

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

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

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

Revised: 10/2019

SPECIAL THANKS TO OUR ANNUAL CORPORATE SPONSORS!

Platinum Level

KAISER PERMANENTE®

aga

Gold Level

Anthem®

Independent licensee of the
Blue Cross Association.

Silver Level

WARNER Pacific

Word&Brown®

BRi

Bronze Level

health net

Health plans that fit every business.

You may face different business challenges today than you face tomorrow. From traditional copayment plans to plans with cost-sharing arrangements, we'll help you find a solution that fits the needs of your business no matter how they evolve. Learn more at **kp.org/choosebetter.**

Choose Better. Choose Kaiser Permanente.

KAISER PERMANENTE® | Business

OCAHU
Orange County Association of Health Underwriters
1442 E. Lincoln Ave., PMB 441
Orange, CA 92865-1934

Prsrt Std
US Postage
PAID
Alert Direct
Mail

- THE C.O.I.N. -

Please join us at our events!

UPCOMING EVENTS

Legislative Updates from Shore to Shore
- East Anaheim Community Center
JANUARY 10, 2023

Annual Sales Symposium
- Spring Field Banquet Center-Fullerton
FEBRUARY 9, 2023

2023 NAHU Capitol Conference
- Hyatt Regency Capitol Hill-Washington, DC
FEBRUARY 23, 2023

March Luncheon Meeting
- Lake Forest Community Center
MARCH 14, 2023

26th Annual Take a Swing Fore the Cure Charity Golf Classic
- Aliso Viejo Country Club
APRIL 10, 2023

CAHIP Capitol Summit
- Kimpton Sawyer Hotel-Sacramento, CA
MAY 8, 2023

20th Annual Celebration of Women in Business Luncheon & Charity Fashion Show
- Balboa Bay Resort
JUNE 2, 2023

Visit our website for more details

www.ocahu.org

linkedin.com/groups/4100050 **facebook.com/OCAHU** **@OrangeCountyAHU**