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ORANGE COUNTY CAHIP
California Agents & Health Insurance Professionals
CALIFORNIA'S BENEFIT SPECIALISTS

C. O. I. N.

COUNTY OF ORANGE INSURANCE NEWS

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Inside

THIS ISSUE:

National Association of Health Underwriters Gold Certified 2022

NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS 2022 PACESETTER AWARD

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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

Welcome to 2023. A new year is here, and it is filled with so many possibilities!

CAHIP OC had a great legislative meeting in January featuring the two super stars of legislation, Marcy Buckner and Faith Borges. So much of what happens in DC and Sacramento affects the health insurance community, and our association wants to keep our members informed.

I hope you have planned to attend the Sales Symposium, The Great Opportunity. This year it is being held at the Springfield Banquet Center in Fullerton. This will be one of the best symposium's we've had. We are privileged and honored to have Andy Hill, motivational speaker, and former President of CBS Programming. As the old saying goes, "he's going to knock your socks off!" In addition, we have lined up an amazing opening speaker, Ryan Miller. Throughout the day we will have breakout sessions to appeal to all of our members.

In March we will have two carrier panels comprised of small group carriers and Medicare carriers.

Don't forgot to sign up for the annual Swing Fore the Cure golf tournament at Aliso Viejo Country Club. Registration will be open soon.

Let's make 2023 the best year yet!

##

NABIP Operation Shout!

The National Association of Benefit and Insurance Professionals (NABIP) is the leading professional association for health insurance agents, brokers, general agents and consultants. Our members work every day with individuals, families and employers of all sizes to help them purchase health insurance coverage and use that coverage in the best possible way. As a dedicated group of more than 100,000 benefit specialists from across the nation, we advocate on behalf of American health insurance consumers.

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. When you click on "write" you will have the option of using the message we have already created, which takes less than a minute, or composing your own. Either method is effective and sends a strong message to your member of Congress about the important issues facing us today. You can also check back at any time to view and send archived messages. When engaging in NABIP grassroots operations, remember that we are most effective when we speak with one voice. As always, if you have any questions, please feel free to contact us!

When you meet with your federal legislators back in the districts throughout the year, we encourage you to send us your feedback on those meetings. This helps us to keep up the conversation here in Washington. If you have a personal relationship with any legislator, please let us know by filling out our grasstops survey! For more on NABIP's Government Relations operation, click here.

Feature Article:

Annual ACA IRS Reporting Overview and Employee References

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

The Affordable Care Act (ACA) requires each Applicable Large Employer (ALE) to report to the IRS on its compliance with the ACA's Employer Mandate at the conclusion of the compliance calendar year. Copies of such reports must also be distributed to employees by ALEs.

ALEs are employers that must comply with the Employer Mandate. An ALE may be a single company or may consist of multiple companies that are combined because of common ownership (such as parent and subsidiary entities or other related/affiliated businesses), which the IRS calls a Controlled Group.

ALE status is determined annually at the start of each year, by averaging the employer's workforce size over all 12 months of the preceding calendar year. An employer resulting with 50 or more Full Time (FT) plus Full Time Equivalent (FTE) employees in this calculation is considered an ALE for the entire new calendar year.

At the completion of the calendar year, the ALE must report to the IRS on its compliance with the ACA's employer mandate. During reporting season, the ALE must create a report using IRS Form 1095-C, for any person employed full time for at least one full calendar month of the compliance year. Those reports must detail the coverage offered, the cost of coverage (after the employer's contribution, at the employee only rate), affordability safe harbors, and more.

Employers that are considered ALEs in 2022 are conducting their ACA IRS reporting now in Q1 2023, to demonstrate compliance with the mandate during the 2022 calendar year. Forms must be submitted to the IRS by the end of February if submitting via paper, or by the end of March if submitting electronically; copies must be furnished to all employees by March 2, 2023.

PURPOSE OF ACA IRS REPORTING

At the conclusion of an ALE's calendar year, each ALE must report the coverage it offered (or did not offer) to any person employed full time for at least one calendar month to the IRS, for that previous tax year. The ACA IRS reporting determines two major items:

1. Employees' eligibility for Premium Tax Credits (PTCs, subsidies) on the state Exchange/Marketplace (i.e., Covered California, Nevada Health Link, etc.). Employees and families who are made offers of affordable ACA-compliant coverage by an employer are not eligible for Premium Tax Credits/premium subsidies on a state Exchange.
2. The ALE's compliance with the ACA employer mandate. This may include potential noncompliance penalty assessments on the ALE by the IRS. ALEs must report on the coverage offered – or *not* offered – to FT employees and their dependents, but at the employee-only rate (after the employer's contribution). ALEs do not report on the coverage in which the employee is enrolled. ALEs only report on the lowest-cost ACA-compliant plan offered, at the employee-only rate (after the employer's contribution).

WHO REPORTS?

ALEs must report on their compliance with the employer mandate, detailing coverage offered to eligible full-time employees. Additionally, employers *of all sizes* that sponsor self-funded plans must report on coverage maintained by employees and their dependents. This is to enforce the individual mandate, which requires all Americans to obtain and maintain health coverage. At the federal level, there is no penalty for noncompliance. However, several states (including California, but not Nevada) have enacted their

Continued on page 7

Legislative Updates:

By: David Benson - CAHIP-OC VP Legislation

More Families Will Spend Less on Health Care Premiums Thanks to a Fix for the "Family Glitch"

The following article was posted on the NABIP website.

Just in time for open enrollment, the federal government finalized a rule, effective December 12, 2022, that fixes the "family glitch" — a policy that barred millions of workers' family members from receiving subsidized health insurance through the Affordable Care Act (ACA) marketplace. Due to this change, millions of people could be newly eligible to buy ACA coverage and receive financial help with premiums and deductibles. Nearly half of those newly eligible are families of low-income workers (those earning between 100-250 percent of the federal poverty level, or between $28,000-$70,000 a year for a family of four).

The new rule will expand access to affordable coverage for workers' families by using the premium for family coverage — rather than employee-only coverage — to determine family members' eligibility for premium tax credits (PTCs). If a person does not have any offer of employer insurance that meets standards for affordability and adequacy — whether it is through their own employer or through the employer of a household member — that person may now be eligible for PTCs to purchase coverage through the marketplace.

The family glitch resulted from the Internal Revenue Service's 2013 interpretation of the ACA's "firewall" provision. According to the ACA, a person cannot receive PTCs to purchase marketplace coverage if they have an offer of employer-sponsored insurance that meets certain adequacy and affordability standards. An employer plan is considered "affordable" if the employee's premium contribution is less than 9.5 percent of their household income, adjusted for inflation (9.12 percent in 2023).

The IRS previously interpreted the ACA's firewall provision to mean that if a person had an offer of adequate, affordable, employee-only coverage through their employer, their spouse and dependents were unable to receive PTCs to purchase a marketplace plan. This was the case even if the family coverage offered by the employer did not meet the ACA's affordability standards, forcing families to choose between going uninsured or using a large portion of their income to pay for employer-sponsored coverage.

Most of the approximately 5 million people who fell into the family glitch chose the latter option, purchasing employer-sponsored coverage and paying much more than families with similar incomes, who did not fall into the family glitch (they were eligible for PTCs because their working family members did not have an offer of affordable, adequate, self-only coverage from an employer). One study estimated that people in the family glitch spend nearly 16 percent of their household income on employer-sponsored insurance premiums; low-income families in the family glitch pay an average of 22.5 percent of their income on employer-sponsored health coverage.

In contrast, premium contributions for marketplace plans are capped at 8.5 percent of household income.

Not everyone who is newly eligible for PTCs is expected to enroll in marketplace coverage. The final rule estimates that about 1 million more people will receive PTCs over the next ten years due to this change. A separate analysis predicts that around 20 percent of new PTC recipients will gain insurance, while most will see lower premiums after switching from employer-sponsored coverage. This change is not anticipated to have a significant impact on the employer-sponsored insurance market but will lead to meaningful savings for families.

Due to the extension of PTC subsidies in the Inflation Reduction Act, many of these families will be newly eligible for plans with zero-dollar premiums, creating significant household savings just as costs for other essentials are rising. Families of low-paid workers, small business employees, workers in the service industry, and children under age 18 are expected to benefit most.

Those impacted by the family glitch will have important new options to consider when open enrollment for 2023 marketplace plans begins on November 1. Families who have been spending a large proportion of their income on employer coverage and are now eligible for PTCs, will need to compare premium savings and other features of marketplace plans. And the "firewall" remains in place, meaning that even if family members qualify for PTCs, if an employer offers affordable, adequate self-only coverage to the employee, the worker will not qualify. In such situations, the family would need to consider whether the savings from enrolling in marketplace coverage would offset the potential costs of paying two monthly premiums and having two separate deductibles and out-of-pocket maximums. Marketplace navigators and other consumer assisters can help families understand these trade-offs. ##

Annual ACA IRS Reporting from page 5

own individual mandates with noncompliance penalties. California's individual mandate mirrors the ACA's requirements, with noncompliance penalties in effect since 1/1/2020.

Fully insured health insurance carriers also report on the coverage obtained and maintained by individuals and families to enforce the federal and state individual mandates.

Fully insured carriers and non-ALEs with self-funded plans report using IRS Form 1095-B. Copies must be furnished to covered individuals. Forms are due to the IRS by the end of March if filing electronically, and copies are due to covered individuals by March 2, 2023.

ALEs with fully insured and self-funded plans conduct reporting on IRS Form 1095-C. One form must be generated for any person who was employed full-time for at least one or more full calendar month of the calendar year. Each form must be submitted to IRS and copies must be furnished to employees.

OVERVIEW OF ACA IRS FORMS

IRS Form 1094-C must be generated by ALEs and is filed with the IRS. This form contains company information, which tells the IRS who the employer is, how many reports it is submitting, certificates of eligibility, affiliated companies (common ownership), employee count, etc.

IRS Form 1095-C contains employee information, related to the coverage offered by the ALE. An ALE must complete one form for any person employed FT for one full calendar month of the reporting year. State health insurance exchanges and health insurance carriers also use Form 1095 to report coverage held/maintained by the taxpayer. There are three versions of IRS Form 1095, and forms must be filed with the IRS and copies must be furnished to the taxpayer whose information is reported.

Most taxpayers receive multiple Forms 1095 from different entities as follows:

- IRS Form 1095-A is used by the state exchanges, which demonstrates possession of minimum essential coverage (MEC) to the IRS as part of the ACA's Individual Mandate. Anyone with coverage on the state individual exchange (Covered California, Nevada Health Link, etc.) will get this form.

- IRS Form 1095-B is used by health insurance carriers (and non-ALEs with self-funded plans), which demonstrates possession of MEC to the IRS as part of the ACA's individual mandate. This form tells the IRS what coverage was elected and held by the taxpayer. Anyone enrolled in health coverage will receive this form or will have access to it by requesting it from the insurance carrier or health plan. In California, these forms are also submitted to the California Franchise Tax Board to enforce California's individual mandate.

- IRS Form 1095-C is used by ALEs, with both fully insured and self-funded plans. It demonstrates the ALE's compliance with the employer mandate, and reports on coverage offered to employees. For self-funded employers, additional reporting is required to demonstrate possession of MEC health coverage to the IRS for enforcement of the ACA's individual mandate. In California, these forms are also submitted to the California Franchise Tax Board to enforce California's individual mandate.

ACA IRS REPORTING DUE DATES

Copies of forms 1095-C and 1095-B must be furnished to employees/covered subscribers by March 2, 2023.

If filing via paper, forms 1094 and 1095 are due to IRS by the end of February. If filing electronically, the forms are due by the end of March. The IRS requires employers/entities with 250+ Forms 1095 to submit electronically.

If employers need additional time to report to the IRS, an automatic 30-day extension is available via request, utilizing IRS Form 8809. *Note: this 30-day extension only applies to filing dates with the IRS. Employers and plans cannot delay the deadline to furnish copies to covered individuals/employees.*

ACA IRS REPORTING – NONCOMPLIANCE PENALTIES

ALEs and plans that do not file as required by the ACA are subject to reporting noncompliance penalties, in addition to potential noncompliance penalties for violations of the ACA's employer mandate. An employer can be penalized for not submitting forms to IRS, and for not remitting copies of forms to covered individuals – making the penalties effectively double.

For forms submitted not more than 30 days late, the penalty is $50/form. For forms submitted more than 31 days late but before August 1, 2023, the penalty is $110/form. For forms submitted after August 1st, the penalty is $290/form. For intentional disregard, the penalty is $580/form – and there is no limitation on the maximum penalty amount. Noncompliance penalties are capped between $206,000 and $3,532,500/employer, depending on the size of the employer and the tardiness of the forms' submission.

The IRS may impose fines of $280/form upon ALEs that submit ACA IRS forms with incomplete or inaccurate information. ALEs working with third-party vendors to facilitate ACA reporting should review their forms for accuracy before submitting them to the IRS to avoid such penalty.

##

ACA Updates

By: Marilyn Monahan

THE ACA: ALWAYS EVOLVING

Since it was signed into law in March 2010, the Affordable Care Act (ACA) has become one of the dominant features of the health and welfare benefits world. It has also continued to evolve. We have seen some provisions go away (the Cadillac Tax), some become virtually irrelevant (the individual shared responsibility penalty, due to its reduction to zero), some re-evaluated (the Family Glitch), some resurrected (the PCORI fee), some newly emerge (the Transparency in Coverage Final Rule), and some which seem to be perpetually in abeyance (the nondiscrimination rules for fully insured plans). One thing is clear: the ACA never remains static. And this constant evolution creates challenges, but also opportunities, for producers and benefit professionals.

So, where do we stand and what are the latest developments which we should be focusing on for 2023?

TRANSPARENCY IN COVERAGE (TiC) FINAL RULE

One of the newest ACA developments—the TiC Final Rule—is a set of regulations that creates two new disclosure requirements for group health plans and health insurance issuers offering group and individual coverage. The authority for these regulations is in the original text of the ACA—section 1311(e)(3)—but the final version of the regulations was not actually published until 10 years later (November 2020), and the first effective date did not kick in until 2022.

Machine-Readable Files: The first part of the TiC Final Rule is the machine-readable files (MRFs) mandate. Under this mandate, non-grandfathered group health plans and health insurance issuers must disclose—on a public website—and in three separate machine-readable files (MRFs)—information regarding (a) in-network rates for covered items and services, (b) out-of-network allowed amounts and billed charges for covered items and services, and (c) negotiated rates and historical net prices for covered prescription drugs. The last MRF in this list—relating to prescription drugs—has been delayed indefinitely, but the first two MRF requirements went into effect July 1, 2022, for plan years beginning on or after January 1, 2022. For 2022 plan years beginning subsequent to July 1, 2022, plans and issuers were required to post the two MRFs in the month in which the plan year (in the individual market, policy year) began. The effect of this implementation structure is that with the end of 2022, all non-grandfathered group health plans should be in compliance with the mandate.

On-Line Price Comparison Tool: The second part of the TiC Final Rule—the on-line price comparison tool—has a staggered implementation process, with the first component going into effect in 2023.

For those of you who have studied the MRFs, you will know that, despite a plain language requirement, the MRFs are not very user-friendly. In contrast, the price comparison tool is intended to be very user-friendly, by providing participants and beneficiaries with individually tailored price information for covered items and services that will allow them to shop and compare. According to CMS, "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 costs before receiving care."

Under the rules, participants should be able to enter a billing code (or description of a service or item) and a provider name and have the system generate an estimate of their cost-sharing liability for that service with that provider. The cost-sharing estimate will be calculated based on accumulated amounts (for example, how much the participant has already incurred toward their deductible), the in-network rate (including the negotiated rate and the underlying fee schedule rate), and the out-of-network allowed amount.

The estimate will include additional disclosures, such as a notice explaining whether coverage of the item or service is subject to a prerequisite. A plain language statement will also be included that explains the participant may receive a balance bill, actual charges may differ, the estimate is not a guarantee, whether the plan counts copayment assistance or other third-party payments in the calculation of the deductible or out-of-pocket maximum, an item or service may not be subject to cost-sharing if preventive care, and any additional information or disclaimers the plan deems appropriate. Upon request, the data must be provided on-line, in paper form, and by telephone.

The price comparison tool must be available to participants and beneficiaries for plan years beginning on or after January 1, 2023, with respect to 500 shoppable items and services, and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024. The 500 shoppable services that must be included have already been identified by the Departments implementing the mandate (Treasury, Labor, and Health and Human Services).

If your plan is fully insured, you may satisfy both the MRF and the on-line price comparison tool mandates by entering into a written agreement with your carrier to provide the information. If your plan is self-funded, you may also satisfy these requirements by entering into a written agreement with a third party (such as a TPA or ASO). However, in the case of a self-funded plan, if the contracted third party fails to provide the required information, the plan will be deemed to be in violation of the Final Rule (and subject to any applicable penalties).

As noted above, the TiC Final Rule's MRF mandate does not

Continued on page 9

apply to grandfathered plans. The price comparison tool mandate in the TiC Final Rule also does not apply to grandfathered plans—but an almost parallel provision in the Consolidated Appropriations Act, 2021 (the CAA) does. As a result, both grandfathered and non-grandfathered plans must provide their participants and beneficiaries with the price comparison tool.

IRC SECTION 4980H PAYMENTS

Significantly, since 2015, the ACA has required "applicable large employers" (ALEs) to offer their full-time employees (and their dependent children) "minimum essential coverage" (MEC) that is also "minimum value" (MV) and "affordable." Failure to offer MEC, MV, affordable coverage to a sufficient number of full-time employees could result in the employer receiving a 226J letter from the Internal Revenue Service (IRS) proposing an Internal Revenue Code (IRC) section 4980H(a) or (b) penalty. Appropriately, section 4980H continues to drive decisions ALEs make each year about the coverage they will offer, to whom, and at what cost.

The (a) and (b) penalties adjust each year:

	2015	2016	2017	2018	2019	2020	2021	2022	2023
4980H(a)	$2,080	$2,160	$2,260	$2,320	$2,500	$2,570	$2,700	$2,750	$2,880
4980H(b)	$3,120	$3,240	$3,390	$3,480	$3,750	$3,860	$4,060	$4,120	$4,320

Coverage is "affordable" if the amount of the employee's monthly contribution toward self-only coverage under the employer's lowest-cost plan satisfies one of three safe harbor methodologies: W-2, rate of pay, or federal poverty line (FPL). The percentage used to calculate affordability adjusts each year. Over time, the percentage has been:

2015	2016	2017	2018	2019	2020	2021	2022	2023
9.56%	9.66%	9.69%	9.56%	9.86%	9.78%	9.83%	9.61%	9.12%

Each year prior to open enrollment, ALEs and benefit professionals should ensure that MEC coverage is being offered to at least 95% of the ALE's full-time employees (and their dependent children). In addition, ALEs and benefit professionals should be running the numbers to ensure that, using one or more of these safe harbors, the MEC, MV coverage being offered is "affordable." Taking these steps will help to ensure that the ALE avoids the 4980H penalties.

2022 IRS FORMS 1094/1095 REPORTING

To determine whether an employer may or may not owe a 4980H penalty, the IRS needs the data provided in the Forms 1094/1095-C. Therefore, ALEs must continue to prepare, furnish, and file these forms each year. (Small employers that self-fund must also prepare, furnish, and file the Forms 1094/1095, but they use the B-series forms rather than the C-series forms.)

Under the law, the Forms 1095-C must be mailed to employees by January 31 (the same day as W-2s must go out). Each year since 2015, however, the IRS has given employers an automatic 30-day extension to distribute the forms. This year, it was announced that the extension has been made permanent. Every year going forward, employers have until March 2 to mail the forms. No further extensions will be granted, however.

The applicable IRS deadlines for furnishing and filing the 2022 Forms 1094/1095-C are:

Employer Obligation	Due Date
Furnishing 1095-Cs to Employees	**March 2, 2023** (no additional extensions)
Filing 1094-C and 1095-Cs with the IRS (on paper)	**February 28, 2023**
Filing 1094-C and 1095-Cs with the IRS (electronically) (required if filing ≥250 1095-Cs)	**March 31, 2023**

The same IRS announcement extending the deadline to furnish the Forms 1095-C included more good news if you are an insurance company. Insurers do not have to mail the Form 1095-B to all participants—in 2023 or in the future. Instead, the insurer may provide a clear and conspicuous notice on its website explaining that the form is available upon request. Then, if a request is received, the Form 1095-B must be furnished within 30 days. (This option does not apply to ALEs furnishing their full-time employees with the Form 1095-C; ALEs still have to distribute the Form 1095-C to full-time employees.)

Tax preparers sometimes ask their clients for copies of both the Form 1095-C (which they should receive from their employer) and the Form 1095-B (which they should receive from their insurer), prompting employees to then ask the human resources department or the producer where they can find these forms. So, it is helpful for producers and benefits professionals to know that the insurer typically does not mail the Form 1095-B to participants, but it is available upon request.

Finally, this same notice included another very important announcement for employers: The IRS confirmed that good faith penalty relief is no longer available. This means that if an employer furnishes and files the 2022 Forms 1094/1095 on time, but the forms are not filled out completely or accurately, the employer could be subject to penalties under sections 6721 and 6722 of the IRC (unless the employer can show that the failure was due to reasonable cause and not willful neglect). Good faith penalty relief had been available up until last year, but seven years into the reporting mandate, the IRS has decided that the relief is "no longer appropriate." With this announcement, there is increased pressure on employers to ensure not only that they file and furnish the forms on time, but that they fill them out properly.

What are the penalties if an employer fills out the forms incorrectly? They are the same penalties that apply if the employer fails to furnish and file the forms on time. For the 2022 forms, the penalty could be up to $290 per form (the penalties could be lower if the forms are filed within certain timeframes). These IRS penalties adjust each year. Over time, these penalties have been:

	2015 Penalty	2016 Penalty	2017 Penalty	2018 Penalty	2019 Penalty	2020 Penalty	2021 Penalty	2022 Penalty
Failure to file with IRS (max)	$250 ($3M)	$260 ($3,193,000)	$260 ($3,218,500)	$270 ($3,275,500)	$270 ($3,339,000)	$280 ($3,392,000)	$280 ($3,426,000)	$290 ($3,532,500)
Failure to furnish to employee (max)	$250 ($3M)	$260 ($3,193,000)	$260 ($3,218,500)	$270 ($3,275,500)	$270 ($3,339,000)	$280 ($3,392,000)	$280 ($3,426,000)	$290 ($3,532,500)
Intentional disregard	$500 (no cap)	$530 (no cap)	$530 (no cap)	$540 (no cap)	$550 (no cap)	$560 (no cap)	$560 (no cap)	$580 (no cap)

For example, if an employer fails to file and furnish one Form 1095-C on time, the employer could be penalized $290 for failure to furnish the form, and another $290 for failure to file the form. If the form is furnished and filed on time, but it contains errors, the IRS can impose a $290 penalty per form for that

Continued on page 11

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.

LAB PAYS $16,500 SETTLEMENT TO HHS, RESOLVING POTENTIAL HIPAA VIOLATION OVER MEDICAL RECORDS REQUEST

In this issue, I have a few cases to report on from HHS/OCR related to HIPAA Privacy & Security and other federal legislation and regulation.

Lab Pays $16,500 Settlement to HHS, Resolving Potential HIPAA Violation over Medical Records Request

On January 3, 2023, the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services announced a settlement with Life Hope Labs, LLC ("Life Hope Labs"), a full-service diagnostic laboratory in Sandy Springs, Georgia, concerning a potential violation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule's right of access provision. The rule requires that patients be able to access their health information in a timely manner. This investigation marks the 43rd case to be resolved under OCR's HIPAA Right of Access Initiative, designed to improve compliance by regulated entities with the law. Life Hope Labs agreed to implement a corrective action plan and pay $16,500 to resolve this investigation.

"Access to medical records, including lab results, empowers patients to better manage their health, communicate with their treatment teams, and adhere to their treatment plans. The HIPAA Privacy Rule gives individuals and personal representatives a right to timely access their medical records from all covered entities, including laboratories," said OCR Director Melanie Fontes Rainer. "Laboratories covered by HIPAA must follow the law and ensure that they are responding timely to records access requests."

In August 2021, a complaint was filed with OCR alleging that Life Hope Labs would not provide a personal representative with a copy of her deceased father's medical records. The personal representative first requested access to her father's records on July 7, 2021, but did not receive them until February 16, 2022, over seven months later. OCR's investigation determined that Life Hope Labs' failure to provide timely access to the requested medical records was a potential violation of the HIPAA right of access provision.

In addition to the monetary settlement, Life Hope Labs also agreed to implement a corrective action plan that includes two years of monitoring by OCR. A copy of the resolution agreement and corrective action plan may be found at: https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/life-hopes-ra-cap/index.html.

HHS ISSUES NEW STRENGTHENED CONSCIENCE AND RELIGIOUS NONDISCRIMINATION PROPOSED RULE

On December 29, 2022, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) announced a Notice of Proposed Rulemaking (NPRM), entitled Safeguarding the Rights of Conscience as Protected by Federal Statutes, which proposes to restore the longstanding process for the handling of conscience complaints and provide additional safeguards to protect against conscience and religious discrimination.

"No one should be discriminated against because of their religious or moral beliefs, especially when they are seeking or providing care," said Secretary Xavier Becerra. "The proposed rule strengthens protections for people with religious or moral objections while also ensuring access to care for all in keeping with the law."

"Protecting conscience rights and enforcing the law to combat religious discrimination is critical," said Office for Civil Rights Director Melanie Fontes Rainer. "Today's proposed rule would strengthen these protections and reinforce our long-standing process for handling such conscience and faith-based objections. It also would take steps to help ensure that individuals are aware of their rights."

In 2019, OCR issued a regulation that provided broad definitions, created new compliance regulations, and created a new enforcement mechanism for a number of statutes related to the conscience rights of certain federally funded health care entities and providers. The 2019 Final Rule was held unlawful by three federal district courts. In light of these court decisions, and consistent with the Administration's commitment to safeguard the rights of federal conscience and religious nondiscrimination while protecting access to care, this NPRM proposes to partially rescind the Department's 2019 rule while reinforcing other processes previously in place for the handling of conscience and religious freedom complaints.

Public comments on the NPRM are due 60 days after publication of the NPRM in the Federal Register.

The NPRM may be viewed here: https://www.hhs.gov/sites/default/files/conscience-rule-nprm.pdf - PDF*

Continued on page 11

Compliance Corner, cont. from page 10

HHS Civil Rights Office Resolves HIPAA Right of Access Investigation

On December 15, 2022, the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services announced a settlement with Health Specialists of Central Florida Inc., a provider in Florida that provides primary care, concerning a potential violation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule's right of access provision. The rule requires that patients be able to access their health information in a timely manner. This investigation marks the 42nd case to be resolved under OCR's HIPAA Right of Access Initiative, designed to improve compliance by regulated entities with the law. Health Specialists of Central Florida Inc. paid $20,000 to OCR and agreed to implement a corrective action plan (CAP) to resolve this investigation.

"The right of patients to access their health information is one of the cornerstones of HIPAA, and one that OCR takes seriously. We will continue to ensure that health care providers and health plans take this right seriously and follow the law," said OCR Director, Melanie Fontes Rainer. "Today's announcement speaks to the importance of accessing information and regulated entities taking steps to implement i procedures and workforce training to ensure that they are doing all they can to help patients access."

In August 2019, a complaint was filed by a daughter acting as a personal representative on behalf of her deceased father, who had been a patient of Health Specialists of Central Florida Inc. The complainant alleged that Health Specialists of Central Florida Inc. had failed to provide her with timely access to the requested medical records, despite multiple requests.

OCR's investigation determined that Health Specialists of Central Florida Inc.'s failure to provide timely access to the requested medical records was a potential violation of the HIPAA right of access standard, which requires a covered entity to take action on an access request within 30 days of receipt (or within 60 days if an extension is applicable). As a result of OCR's investigation, the daughter finally received all of the requested records, nearly five months after her initial request.

In addition to the monetary settlement, Health Specialists of Central Florida Inc. will undertake a 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/health-specialists-ra-cap/index.html.

OCR's guidance on the right of access is available at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html.

Stay tuned for more updates in the next issue of The COIN!

##

ACA Updates cont. from page 9

error as well.

2022 FORMS 1095-C REPORTING: THE FRANCHISE TAX BOARD

While the ACA individual shared responsibility penalty was reduced by Congress to zero, several states now have an individual coverage mandate (CA, DC, NJ, MA, RI, and VT), requiring residents of those states (or DC) to have health coverage. In order to monitor compliance with these mandates, most of these jurisdictions require employers to furnish forms to their employees and file those forms with state tax authorities. These state mandates are in addition to the required IRS reporting.

For example, if you have employees in California, and your plan is self-funded, in addition to filing with the IRS, under state law you are also obligated to furnish the Forms 1095-C to employees and then file them with the Franchise Tax Board (FTB). (If your plan is fully insured and the insurer files its Forms 1095-B with the FTB, the employer does not have to file the C-series forms.) These are the FTB's deadlines for furnishing and filing the 2022 Forms 1095-Cs:

Insurer/Employer Obligation	Due Date
Furnishing Forms 1095-B/C to Employees	**January 31, 2023**
Filing Forms 1094/1095-B/C with the FTB (electronic filing required if filing ≥250 1095-Cs)	**March 31, 2023** (extended to **May 31, 2023**)

THE FAMILY GLITCH

In another notable change to existing ACA rules, on October 13, 2022, the IRS issued a final rule on the "Affordability of Employer Coverage for Family Members of Employees." (87 Fed. Reg. 61979.) This final rule eliminates the "family glitch" which has been in effect since the ACA Marketplaces were created and section 4980H went into effect. The final regulations on the Family Glitch were effective on December 12, 2022, and they apply to taxable years beginning after December 31, 2022.

Under ACA practice before this final rule took effect, if an ALE offers full-time employees and their family members MEC coverage that is also MV and "affordable," the employee, spouse, and dependent children are all ineligible for a premium tax credit (PTC) if they waive employer coverage and instead purchase a policy from a Marketplace (such as Covered California). This was true even though the employer's affordability calculation was based only on the amount the employee was asked to pay for self-only coverage. In other words, even if the employer does not contribute any amount toward the cost of family coverage, the employee's spouse and dependent children would not be eligible for a PTC, if the cost of employee-only coverage was deemed affordable under the ACA's rules. This is the "family glitch."

Continued on page 12

ACA Updates cont. from page 11

The new final rule does not change how employers calculate affordability for ACA purposes, and does not subject ALEs to any additional penalty exposure under section 4980H. However, under the final rule, Marketplaces (such as Covered California) will take into account the cost of dependent coverage for the employer's lowest cost MV plan when determining whether the spouse and dependent children are eligible for a PTC. If the cost of coverage for the spouse and dependent children under the employer's MV plan exceeds the affordability threshold, the spouse and dependent children will be eligible for a PTC if they decline the employer's plan and purchase a policy through the Marketplace instead.

Although employers will not have to change how they calculate affordability under this rule, employers might want to consider whether and how much they might contribute toward the cost of dependent coverage, and the impact those contributions may have on enrollment in the employer's plan. With this change, more family members could decide to decline employer-sponsored coverage in favor of a Marketplace plan. At the same time, if family members decide to split coverage between the employer's plan and the Marketplace, they will have to meet separate deductible and out-of-pocket limits. As a result of this new rule, both employers and employees will have some decisions to make when the next open enrollment period rolls around.

PCORI FEE

The Patient-Centered Outcomes Research Institute (PCORI) Fee was originally scheduled to expire, but it was resurrected for 10 more years through the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94), signed into law on December 20, 2019. The PCORI fee mandate now ends in 2029.

The IRS announced this fall—as it does each year—that the PCORI fee for policy and plan years that end on or after October 1, 2022, and before October 1, 2023, is $3.00. (IRS Notice 2022-59.) For plan and policy years that end on or after October 1, 2021, and before October 1, 2022, the fee is $2.79 (the latter fee amount was previously announced in IRS Notice 2022-4).

Self-funded plans must file IRS Form 720, and pay the applicable PCORI fee, each year on July 31. The filing deadline is not based on the plan year--everyone files on July 31.

PREVENTIVE CARE

Under the ACA, non-grandfathered health plans must cover preventive services without cost-sharing when the services are provided in-network. During the pandemic, COVID-19 vaccines became a part of this preventive care mandate. But this is not the only recent adjustment to the scope of the preventive care mandate, and these changes mean expanded coverage for participants and beneficiaries.

For plan years beginning on or after December 30, 2022, the preventive services guidelines for women have been updated so that there will be enhanced coverage of breastfeeding services and supplies, well-woman preventive care visits, access to contraceptives and contraceptive counseling, screening for human immunodeficiency virus (HIV), and counseling for sexually transmitted infections (STIs). In addition, a new guideline was approved that aims to prevent and reduce obesity in midlife women (ages 40 to 60) through counseling. (87 Fed. Reg. 1763.)

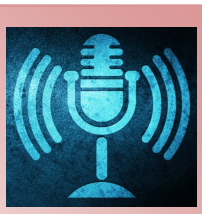
The scope of preventive services for infants, children, and adolescents was also expanded by adding universal screening for suicide risk to the current Depression Screening category for individuals ages 12 to 21; new guidance for behavioral, social, and emotional screening; new guidance for assessing risks for cardiac arrest or death for individuals ages 11 to 21; and new guidance for assessing risks for hepatitis B virus infection in newborn to 21 year-olds.

CONCLUSION

The ACA continues to drive many of the decisions employers and producers make each year as they decide which benefit packages to offer, and how much they should ask employees to contribute toward the cost of coverage. The ACA has expanded the range of both covered benefits and compliance tools available to participants, but keeping up with and implementing these changes has also created additional challenges. Knowing how the benefits world is evolving, and how Congress, the states, and the marketplace are responding, are essential components of the producer and benefits professional's job.

##

CAHIP Podcast Series



CAHIP's Podcast Series is back at: ***http://anchor.fm/cahu*** and ***https://www.cahu.org/podcasts*** or on Spotify! (search CAHU) or at cahip.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?**
- **CAHIP Medicare Updates - Part 1**
- **CAHIP Medicare Updates - Part 2**
- **CAA's No Surprises Act**

NABIP Professional Development: Membership has its "Awards"

By: Sarah Knapp - CAHIP-OC Awards Chair

One of the benefits of being a NABIP Member is the opportunity to enhance your knowledge and obtain awards and designations through various programs. Below are two prestigious awards and NABIP's REBC program. Visit the Professional Development section of the NABIP Website for more details on all Professional Development resources.

LPRT

The **Leading Producers Round Table** was formed by NABIP in 1942 to recognize the successful underwriters of Accident & Health Insurance. Today, the LPRT committee is committed to making LPRT the premier program for top Health, Disability, Long Term Care and Worksite Marketing Insurance producers, carrier reps, carrier management and general agency/agency managers.

As the saying goes, "membership has its rewards" and as a member of the Leading Producer's Round Table (LRPT), you will have the recognition of your peers for being one of the top performers in our business. LRPT members also receive discounts on many NABIP services and meetings. There are exclusive LPRT-only events held as well.

The qualification categories are:

- **Personal Production:** Business written by a single producer.
- **Carrier Representatives:** An employee of an insurance carrier working with producers.
- **Agency:** Management of a general agency or agency.
- **Carrier Management:** Carrier/home office sales managers, directors of sales and vice president sales

Visit Membership Resources on the NABIP website for more information on how you can qualify for this exclusive membership.

TRIPLE CROWN AWARD

Another **AWARD** through NABIP is the **President's Triple Crown Programs.** The program was created to recognize those members whose individual contributions to NABIP help advance the association's mission. Like any Triple Crown, it recognizes accomplishment in three key areas. To qualify for the Triple Crown, within a calendar year a member must cover the following areas:

- **HUPAC:** Participate in the $10 x 12 draft program or contribute $150 total. This is a separate from your CAHIP PAC contribution.
- **Membership:** Recruit at least two new members.
- **Advocacy:** Use Operation Shout to send at least three messages.

That's it…. t's as simple as 1, 2, 3! To find out more about the President's Triple Crown Program, visit Contribution Levels & Benefits on the NABIP Website.

REBC

Earning the **Registered Employee Benefits Consultant®** (REBC®) designation elevates your credibility as a professional. The field of employee benefits continues to evolve rapidly. To best serve their clients, professionals need to have a current understanding of the requirements, benefits, and restrictions associated with each type of benefit or program as a method for meeting economic security. The designation program analyzes group benefits with respect to the ACA environment, contract provisions, marketing, underwriting, rate making, plan design, cost containment, and alternative funding methods. The largest portion of this course is devoted to group medical expense plans that are a major concern to employers, as well as to employees. The remainder of course requirements include electives on topics serving various markets based on a broker's client needs

To find out more visit Registered Employee Benefits Consultant (REBC) Designation on the NABIP website.

##

CAHIP-OC Board of Directors and Staff 2022-2023

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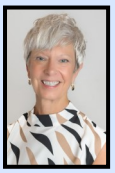

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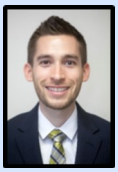

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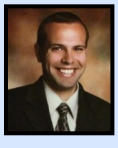


DIVERSITY & INCLUSION
Eric Terrazas
Colonial Life
eterrazas@coloniallifesales.com

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

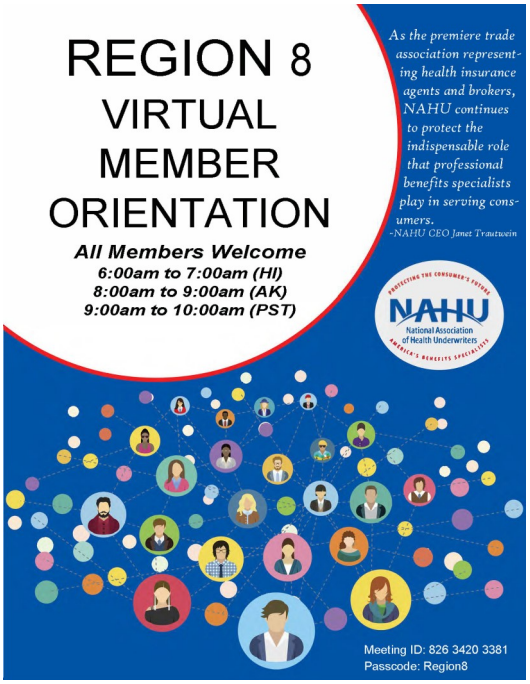
We are committed to helping agents and brokers reach new heights in their careers through Continuing Education course, seminars, conferences and more.

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.



Interested in Joining? Many ways to join:

- **Contact our Membership Team:**

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☎ (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

Capitol Conference 2023 will be in person. The conference is February 26 -March 1 at the Hyatt Regency on Capitol Hill in Washington DC. This unique and inspiring meeting has the potential to be a game-changer this year. Be a part of making important changes happen. Join your NABIP colleagues in our nation's capital and make a difference in the health-reform debate.

Event Agenda

REGISTER

Monday, February 27

7:30 a.m. - 5:00 p.m. — Capitol Conference Registration
7:30 a.m. - 9:00 a.m. — Breakfast with Sponsors
8:00 a.m. - 9:00 a.m. — Breakout Meetings:

- *State and Local Legislative Chairs*
- *NABIP PAC Chairs*
- *Media Chairs*

9:15 a.m. - 12:00 p.m. — General Session

- *Welcome*
- *Introductions of NABIP Board of Trustees, NABIP PAC Board of Trustees, and NABIP Legislative Council*
- *Expectations of Event*
- *NABIP PAC and Legislative Awards*
- *Keynote: TBA*
- *Federal Priorities Briefing*
- *Legislative Forum featuring:*
  - *Janet Trautwein, CEO, NABIP*
  - *Marcy Buckner, Sr VP of Government Affairs, NABIP*
  - *Misty Baker, Legislative Chair, NABIP*
  - *Greg Stancil, Vice Legislative Chair, NABIP*

12:00 p.m. - 1:15 p.m. — Lunch on your own
1:15 p.m. - 2:15 p.m. — General Session
2:15 p.m. - 2:45 p.m. — Afternoon Break with Sponsors
2:45 p.m. - 4:30 p.m. — Breakout Sessions

- *Paul Roberts, compliance officer from Word & Brown, introducing the updates to the NABIP ACA and CAA certification course*
- *James Gelfand, president of ERIC, ERISA Industry Committee, discussing "Understanding the Little Things that Make a Big Difference"*
- *Faith Borges, CAHIP lobbyist, and Lauren Crawford Shaver from Partnership for America's Healthcare Future, discussing state public options*
- *Two breakout sessions covering changes and rules for Medicare marketing*

4:45 p.m. - 5:30 p.m. — Regional Meetings

5:30 p.m. — Dinner on your own

Note all times listed are Eastern Time Zone.

Tuesday, February 28

7:30 a.m. - 9:00 a.m. — Breakfast with Sponsors
9:00 a.m. - 12:00 p.m. — General Session

- *Legislators including Rep. Adrian Smith (R) Nebraska, a supporter of NABIP's Commonsense Reporting Act. More legislators will be announced soon.*
- *Association town hall – ask anything about association business with NABIP President Kelly Fristoe, President-Elect Eric Kohlsdorf, Immediate Past President Eugene Starks and CEO Janet Trautwein Members of Congress*
- *Mary Beth Donahue, President and CEO of Better Medicare Alliance, discussing improving access to care in Medicare Advantage for Beneficiaries*

12:00 p.m. - 1:00 p.m. — Lunch on your own
1:00 p.m. - 5:00 p.m. — Lobbying with Members of Congress
6:00 p.m. — NABIP PAC Reception (ticketed event)

Wednesday, March 1

8:00 a.m. - 9:15 a.m. — NABIP PAC Capitol Club Breakfast (Invitation-Only Event)
9:00 a.m. - 5:00 p.m. — Lobbying with Members of Congress

Venue:

Hyatt Regency Capitol Hill
400 New Jersey Ave, NW
Washington, DC 20001
Phone: 202-737-1234

New Compliance Requirement for California Insurance Agents' Email Communications

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

Under new California law (SB 1242) effective January 1, 2023, California insurance agents are required to list their insurance license numbers on all email communications.

Existing California law from the mid-1990s requires insurance agents to print their license numbers on business cards, quotes, and print advertisements. SB 1242 applies these same requirements to agents' electronic mail correspondence involving any activity for which a license is required beginning in 2023. This allows consumers to confirm that the person and/or agency is actively licensed with the California Department of Insurance.

While the law applies to California insurance agents with accident and health or sickness licenses, it also applies to other California insurance licensees such as property and casualty, life, disability, annuity, personal, auto, etc.

In late December 2022, the California Department of Insurance clarified some of its new requirements in a new FAQ document:

- The law applies to every email that involves an activity for which a person/agency must be licensed – regardless of where the emails are sent from or to. The law does not apply to electronic correspondence regarding clerical activities that do not require a California insurance license.
- The license number must appear adjacent to, or on the line below, the individual's name or title.
- The license number must be in a font size that is no smaller than the largest font of any street address, email address, or telephone number of the licensee included in the e-correspondence. For example, if an email includes a 10-point street address, an 11-point email address, and a 12-point telephone number then the license number must be at least 12-point.
- The agent must list the California Department of Insurance license number. An agent cannot list a National Producer Number (NPN) in lieu of a California license number. Furthermore, California DOI clarifies that an agent cannot list a hyperlink under the agent's name that links to a website listing the license numbers for every state where the licensee is licensed (which would include California).
- If an individual licensee sends an email while working for a licensed agency, and both the individual's and the agency's names appear on the email, then both license numbers are to be included in the email.
- If an individual licensee sends an email while working for two or more licensed agencies, that agent's email must include the individual's license number and the license number of every agency whose name appears on the email.

While not included in the CA Department of Insurance's bulletin, following are examples of emails that generally involve an activity for which a person must hold a license in California.

- Explanations or interpretations of, and offering of opinions or recommendations on, insurance coverages, exposures, limits, premiums, rates, deductibles, payment plans, or any other insurance contract, or potential insurance contract or terms
- Recommending, advising, or urging applicants for insurance coverage, potential applicants for insurance coverage, or policyholders to buy particular insurance policies or to insure with particular companies or insurers
- Binding of insurance coverages
- Solicitation
- Negotiations preliminary to execution
- Execution of a contract of insurance
- Transaction of matters after the execution of a contract and arising out of it

Title X, Section 2193.1 of the California Code of Regulations, lists "clerical activities" that do not require licensure include, but are not limited to:

- Distribution of brochures, business cards, or general information advertising insurance agencies, insurers, insurance products, insurance services, etc., provided that unlicensed persons do not analyze, give advice, or make recommendations concerning insurance contracts or potential insurance contract terms to applicants, potential applicants, or policyholders.
- Preparation of applications for insurance coverage without any contact with applicants
- Obtaining underwriting information from third parties
- Preparation of binders, certificates, endorsements, ID cards, policies, and similar evidences of insurance, under the supervision of licensees and for the review and signature of licensees, provided that the unlicensed persons are not signing such documents, either in their names or in the names of the licensees.

The California Department of Insurance welcomes questions to the Producer Licensing Bureau Live Chat on its website, via email at cdilicensing@insurance.ca.gov, or by telephone at 800.967.9331.

Note: this law only applies to California licenses – both resident and non-resident. It does not apply in other states, though other states may follow California's direction in future law(s). ##

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!

SCHEDULE OF EVENTS

CAHIP-OC's Annual Sales Symposium
The Great Opportunity

8:00 - 9:00 am — **Registration, Continental Breakfast, and Exhibit Hall Open**

9:00 - 9:50 am — **High-Performance Habits to Crush Your Goals and Reach Your Potential**
Speaker: Ryan Miller, Performance Coach, Business Consultant, Ryan James Miller
Rose Ballroom, Second Floor

10:00 - 10:30 am — **Cyber Crime, Cyber Risk - Law Enforcement Update**
Speaker, Bryan Willett, Supervisory Special Agent, Cyber Orange County, Federal Bureau of Investigation
Rose Ballroom, Second Floor

10:30 - 11:15 am — **Exhibit Hall Open**
Carnation Hall, First Floor

11:15 am - 12:10 pm — **Breakout Sessions** (Choose one)

- **Cybersecurity - The Keys to Staying Safe (1-HR CE / Course: 388622)**

Panelists: Adriana Mendieta, Tech Coordinator, Cyber Insurance Solutions, Ted Flittner and Ted Mayeshiba, Principals, Aditi Group
Moderator: Dorothy M. Cociu, RHU, REBC, Owner, Advanced Benefit Consulting & Ins. Services
Rose Ballroom, Second Floor

- **Medicare Trends (1-HR CE / Course: 388647)**

Speaker: Louis Valladares, Regional Sales Manager, Applied General Agency
Azalea Room, Fourth Floor

12:15 - 1:00 pm — **Lunch, Announcements, Gold Show Sponsor Welcome, and Pinnacle Award Presentation**
Rose Ballroom and Rose Catering Room, Second Floor

1:00 - 1:45 pm — **Keynote Presentation: The Great Opportunity**
Speaker: Andy Hill, Motivational Speaker, Executive Coach and Bestselling Author
Andy Hill Speaks, Inc.
Rose Ballroom, Second Floor

1:45 - 2:00 pm — **Exhibit Hall Open**
Carnation Hall, First Floor

2:00 - 2:55 pm — **Breakout Sessions** (Choose one)

- **Foundational Ethics and Principles for Health Insurance Agents (1-HR CE / Course: 366636)**

Speaker: Rene Gonzalez, Compliance Analyst, Word & Brown
Azalea Room, Fourth Floor

- **The ACA: The Latest and Greatest (1-HR CE / Course: 388261)**

Speaker: Marilyn A. Monahan, Esq., Owner, Monahan Law Office
Rose Ballroom, Second Floor

3:00 pm — **Grand Prize and Closing**
Rose Ballroom, Second Floor

CAHIP-OC Holiday Luncheon & Orangewood Fundraiser

Brokers Making a Difference

"Our Goal is to help all individuals and employers find appropriate health insurance at an affordable cost"

The Brokers Making a Difference website is designed to inform consumers, legislators and the media about the tireless work agents and brokers do in guiding their clients through the complex task of complying with numerous state and federal regulations while choosing and maintaining appropriate coverage at an affordable price. The website includes an interactive map where people can view specific examples of how brokers help their clients and gain a better understanding of the broker's role as an advocate and educator. This website highlights the vital role of benefit specialists in the health care industry and the value they bring to their clients throughout the year.

Visit: www.brokersmakingadifference.org

The website includes links for:

- Workplace Health Insurance
- Individual and Family Health Insurance
- Medicare

NABIP Healthcare Happy Hour

Subscribe to NAHU's Healthcare Happy Hour

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

Latest Podcasts:

- **Capitol Conference 2023 - How to Meet with Your Legislators**
- **Medicare Mergers and Acquisitions - the Realities of Selling Your Business**
- **NABIP Lobbyist Discuss Important Committee Assignments**
- **What Was in the End-of-Year Omnibus Bill?**
- **Federal Agencies Release Several Proposed and Final Regulations Before Year's End**
- **Employee Benefit Trends with Special Guest Carla Adams**

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

WHAT IS THE ANNUAL VALUE OF NAHU MEMBERSHIP?

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.

- Become the ACA Hero for Your Clients
- Give Employees the Gift of Healthy Pets
- 12 Ways to Say Thank You
- 7 ways to Improve Employees' Financial Wellness

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

Support CAHU PAC!

You don't have to be a member to contribute to the PAC!

CAHU-PAC advocates on behalf of licensed insurance agents and their clients in California on numerous issues of vital concern including their role in solicitation of health, long-term care, annuity and life insurance products, insurance market reform, rising health care costs and regulations affecting agents and brokers.

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

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- THE C.O.I.N. -

Please join us at our events!

UPCOMING EVENTS

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**