Orange County Association of Health Underwriters

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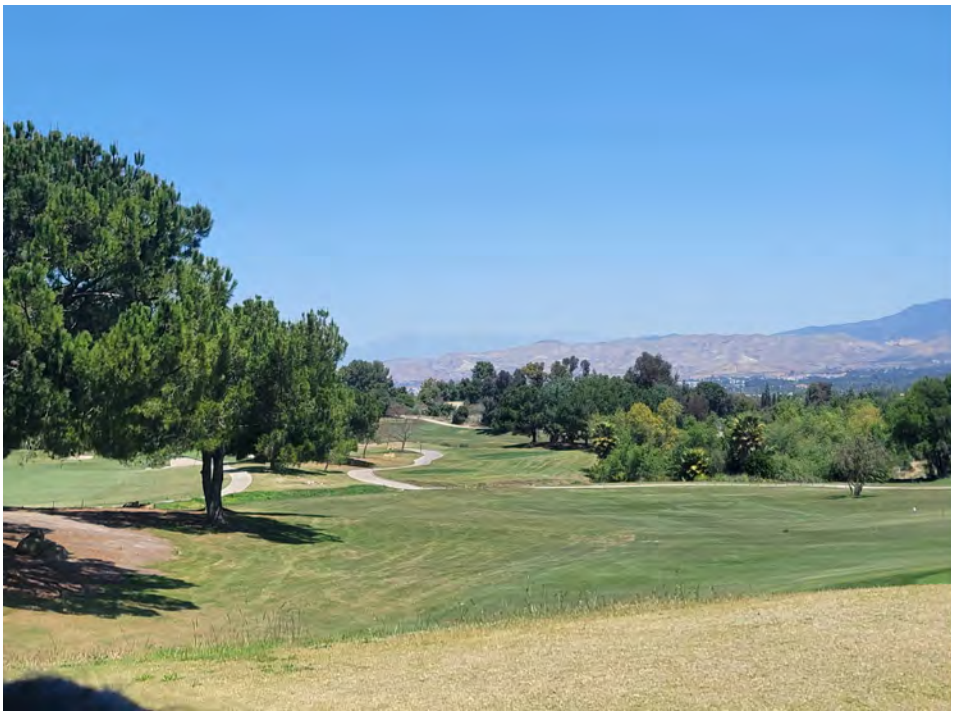
C.O.I.N.

COUNTY OF ORANGE INSURANCE NEWS

OCAHU
Orange County Association of Health Underwriters



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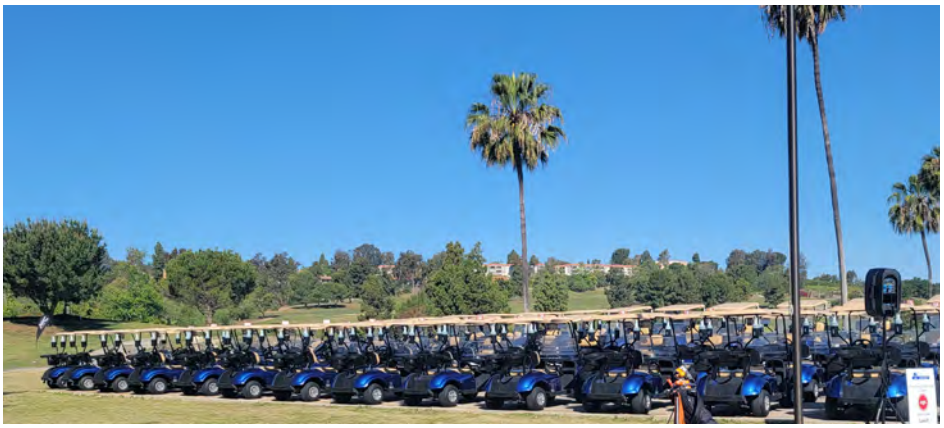

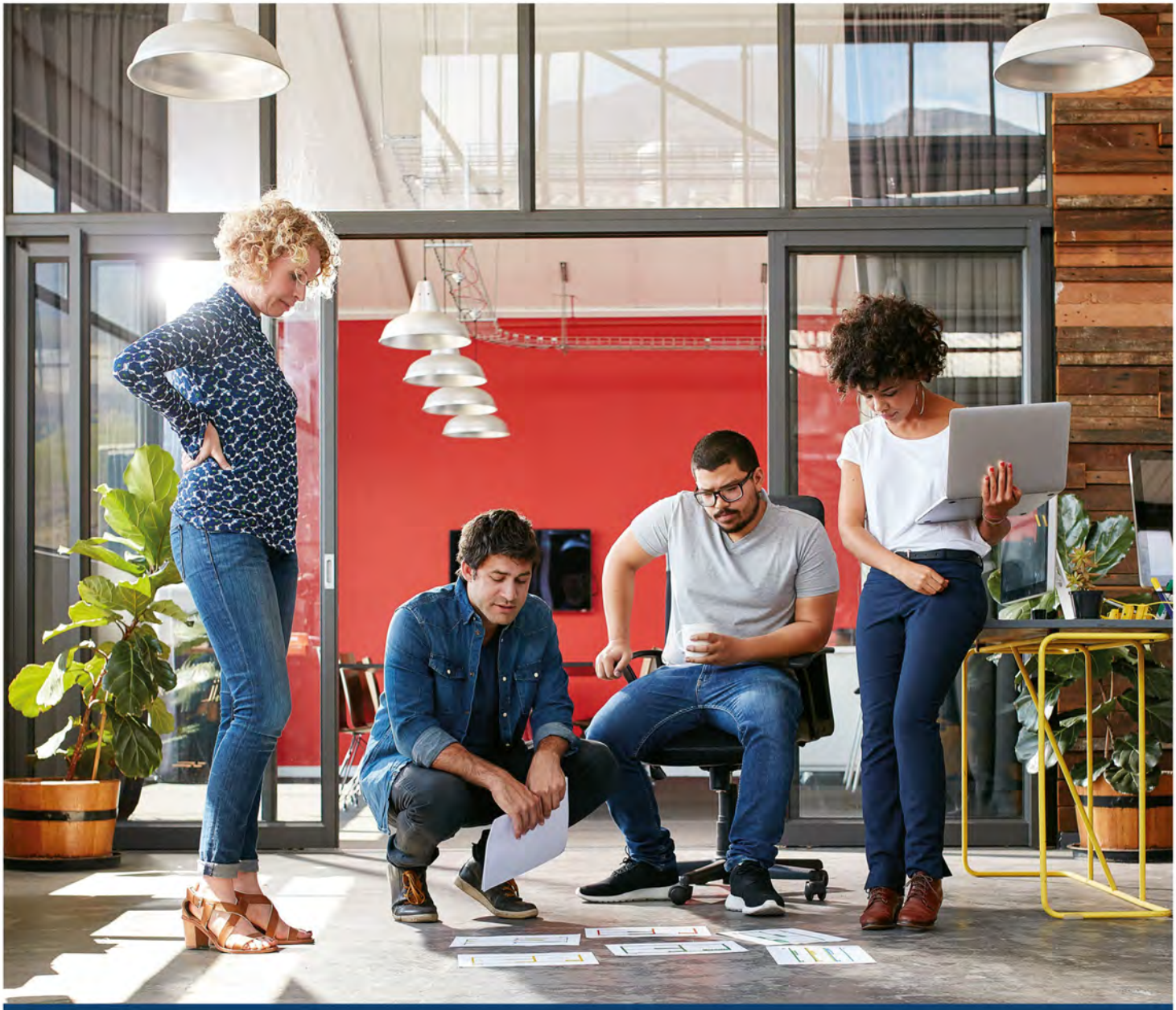

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Thank you for being a part of OCAHU!

What's Inside

OCAHU
Orange County Association of Health Underwriters

National Association of Health Underwriters Gold Certified 2020

Making a Difference in People's Lives.

One Member at a Time.

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

Would you like to be more involved in our industry?

Contact a board member today!

See page 14 for a list of members.

PRESIDENT'S FAREWELL MESSAGE

By: MaryAnna Trutanich, RHU, CHRS

"I have found that among its other benefits, giving liberates the soul of the giver."
-Maya Angelou

As I make my exit as the president of the Orange County Association of Health Underwriters, this quote from Maya Angelou could not ring truer for me. The past two years as President have been nothing short of fulfilling. When I joined the board in 2017 as VP of Professional Development, I was not clear to what my impact would be with the association. I had no previous board experience. I went in with the intention to not only "make a difference" but to become a better association member by giving any and every way I could, all while further advancing the mission of our association. Through guidance, others' experiences and leadership, I was able to understand that to be truly successful, all parts of the association are mutually valuable and must work together.

The role of OCAHU is to promote and encourage the association of professionals in the health insurance field for the purpose of educating, promoting effective legislation, sharing information and advocating fair business practices among our members, the industry and the general public.

As President for the past two years, I truly believe, I helped guide our association to accomplish OCAHU's goals. The pandemic occurred during my second term, although it created challenges, all in all we adapted and were successful.

I want to thank all of you and especially my fellow Board members for helping me be successful. A good leader surrounds themselves with a good team. I've certainly had a very, very good team. It has been an honor and pleasure to have served this association as a board member for over 4 years.

##

Feature Article:

COBRA Subsidy Update: ARP

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

The American Recovery Plan (ARP) Act was signed into law in March 2021, establishing some of the most significant changes to the employee benefits industry since the inception of the Affordable Care Act (ACA) – particularly in the COBRA space. The ARP temporarily provides 100% federally subsided, premium-free COBRA to "Assistance Eligible Individuals" (AEIs) across a six-month window from 4/1/2021 – 9/30/2021.

While helpful to many, the law raises questions and brings significant administrative challenges to employers, carriers, COBRA Third Party Administrators (TPAs), and AEIs. These areas of confusion are addressed by regulations, which follow establishment of any new law. As regulations begin to trickle in from the Department of Labor (DOL), we are learning more about this new law – as detailed in this column. Further regulations and clarity are expected to follow from the IRS, Department of Treasury, and DOL over the coming weeks.

What is COBRA?

COBRA is a federal law that allows a person who has lost eligibility for a group health plan to continue coverage under that same plan for a certain duration of time, usually 18-36 months, depending on the situation. Federal COBRA law applies to employers with 20 or more employees, as of January 1st annually, based on 50% or more of the typical working days of the preceding calendar year.

Some states have "mini COBRA" laws, which provide similar benefit-continuation options, and apply to smaller employers below the federal 20 employee threshold. California's "mini COBRA" law is called Cal-COBRA. Other states, like Nevada, do not have "mini COBRA" options. COBRA is an employer responsibility. Federal COBRA is generally administered by the employer/plan-sponsor, and Cal-COBRA is generally administered by the carrier. ARP regulations specify that the law applies to both federal COBRA and state "mini COBRA" laws. Further regulations are expected, which will give detail to the law's implications — especially on Cal-COBRA administration.

What are ARP's major COBRA changes?

ARP provides temporary, premium-free COBRA continuation options to "Assistance Eligible Individuals (AEIs)" who have *involuntarily* lost eligibility for their group health plans because of an employee's involuntary reduction of hours or involuntary job termination (except for "gross misconduct"). AEIs can be employees, former employees, spouses, former spouses, dependent children, or former dependent children. The caveat is that they must have lost eligibility for their group health plans, due to the employee's involuntary termination or reduction of hours. AEIs are not required to pay their COBRA premiums from April 1st 2021 through September 30th 2021. If an AEI inadvertently pays a COBRA premium for coverage during the subsidy window, the AEI must be issued a refund within 60 days.

According to the new law, each AEI's COBRA premium must firstly be paid by the plan-sponsoring employer, to then later be reimbursed by the IRS when the employer files its quarterly payroll taxes. The subsidy is only available for the six-month period, and cannot be applied retroactively. Additionally, employers can – *but are not required to* – permit AEIs to change their health plan elections to a lower-cost plan than the one previously enrolled in.

Who is eligible to take advantage of the subsidy?

AEIs are eligible for premium assistance ("the subsidy") if they are eligible for and elect COBRA continuation coverage because of their own or a family member's involuntary reduction in hours or involuntary termination from employment. The premium assistance is available for periods of coverage from April 1st 2021, through September 30th 2021. Premium assistance applies to Federal COBRA, as well as "comparable state continuation coverage (mini-COBRA) laws," such as Cal-COBRA.

Assuming the person has lost coverage due to the employee's involuntary job termination or reduction of hours, the person is an AEI who is eligible for the subsidy. This can include a person:

- Who is/was offered COBRA continuation during the six-month subsidy period (04/01/2021 – 09/30/2021
- Who declined to take COBRA continuation when first eligible, as long the person would still have been in his or her maximum COBRA coverage period (had the coverage been initially elected). For Federal COBRA, the period is 18-36 months depending on the situation. For Cal-COBRA, the period is generally 36 months; however,

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it is unclear if ARP applies on an 18-month or 36-month period for Cal-COBRA. Further clarifying regulations will follow. This creates an additional COBRA election period for AEIs in this circumstance.

- Who elected COBRA coverage and later discontinued it, as long as the person would still have been in his or her maximum COBRA coverage period (had the coverage not been discontinued). Again, for Federal COBRA, this period is 18-36 months depending on the situation. For Cal-COBRA, the period is generally 36 months; however, it is unclear if ARP applies on an 18-month or 36-month period for Cal-COBRA. Further clarifying regulations will follow. This creates an additional COBRA election period for AEIs in this circumstance.

AEIs eligible for an additional COBRA election period (the latter two bullet points above) must receive notice of the period informing them of this opportunity. This additional COBRA election notice must be sent by the employer (or the employer's COBRA TPA) by May 31, 2021.

How long does an AEI have to enroll in COBRA to take advantage of the subsidy?

AEIs have 60 days after receiving the provided notice to elect COBRA continuation utilizing the subsidy. If an AEI does not elect COBRA within a 60-day period upon notification, the subsidy is forfeited.

When do COBRA coverage and the subsidy begin?

Individuals can begin their coverage prospectively from the date of their election, or, if an individual has a qualifying event (caused by involuntary job loss or reduction of hours) on or before April 1st, choose to start coverage as of April 1st, even if the individual receives an election notice and makes such election at a later date. In this circumstance, COBRA coverage is applied retroactively.

To which plans does ARP's COBRA premium assistance apply?

ARP regulations clarify that the subsidy provisions apply to **all** group health plans sponsored by employers, subject to Federal COBRA rules under ERISA and/or state mini-COBRA (Cal-COBRA). ARP's subsidy also applies to state or local governments subject to provisions under the Public Health Service Act.

Subsidy Eligibility – "Assistance Eligible Individuals" (AEI)

An AEI is a person who is eligible for COBRA continuation coverage during the period from April 1st 2021, through September 30th 2021, due to a qualifying event that is a reduction in hours, or an involuntary termination of employment and who elects COBRA coverage.

A person is *not* eligible (or loses eligibility) for the subsidy if he or she is (or becomes) eligible for another group health plan (through a spouse, new employer, etc.), or if eligible for Medicare.

Having individual coverage through a state exchange (e.g., Covered California, Nevada Health Link) or Medicaid/Medi-Cal does not nullify an AEI from receiving COBRA subsidy assistance. However, if the individual currently maintains an individual plan on a state exchange, paid through a premium tax credit (PTC), *and* that person elects COBRA via the subsidy, he or she is no longer eligible for the PTC on the exchange during the subsidy period.

Individuals who accept the COBRA subsidy, but become eligible for another group health plan or become eligible for Medicare during the subsidy period, must inform their previous employer/health plan of such. Failure to do so results in a $250 penalty or 110% of the premium assistance. However, regulations clarify that a person will not be subject to the penalty if the failure to notify the employer/health plan is due to reasonable cause and not due to willful neglect.

How does previous COVID-19 National Emergency guidance from the DOL, Department of Treasury, and IRS apply?

Because of the COVID-19 pandemic in 2020, the standard 60-day COBRA election windows were extended to 12 months. Because of this, depending on a person's situation, a person can retroactively elect COBRA as far back as 12 months – if a person had a qualifying event during the previous 12 months as a result of the COVID-19 pandemic. ARP regulations clarify that these extensions do not apply to any timelines created in ARP related to COBRA premium assistance/subsidy. ARP timelines are concrete, and are not impacted by previous COVID-19 National Emergency Guidance.

Employers must notify all eligible AEIs of these changes, subsidies, and enrollment rights.

Employers must notify any person who would be in his or her maximum COBRA period during any of the months in the six-month subsidy period. Because ARP allows people who previously declined or dropped COBRA coverage to re-enroll now, this can include persons involuntarily terminated (or who had a reduction in job hours) as far back as October 2019 (18 months prior to April 2021). As previously stated, this may reach back as far as 36 months prior to April 2021 for Cal-Cobra (March 2018) – though we are awaiting further regulations to clarify. In some instances, Federal COBRA can extend to a 36-month period.

Employers have several notices to distribute, with tight timeframes.

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A General Notice must be provided to all eligible persons who have a qualifying event that is caused by a reduction of hours or involuntary termination of employment from April 1st 2021, through September 30th 2021. This notice can be provided separately or with the COBRA election notice.

- **A notice of the extended COBRA election period to any AEI who had a qualifying event before April 1, 2021.** This notice must be sent to AEIs who are still in their 18-month COBRA window in April, 2021 — and potentially to those who are still in a 36-month Federal COBRA or Cal-COBRA window (depending on the situation), which will likely be clarified in additional forthcoming regulations. This does not include those individuals whose maximum COBRA continuation period, if COBRA had been elected or not discontinued, would have ended before April 1st 2021. (Generally, those with applicable qualifying events before October 1st 2019, for Federal COBRA, and perhaps before March 1st 2018, for Cal-COBRA.) This is due by May 31st 2021.

- **A notice explaining the expiration of periods of premium assistance**, explaining that premium assistance will expire soon, the date of expiration, and that the individual may be eligible for coverage without premium assistance through COBRA or coverage under a different group health plan. Coverage can also be available through a state exchange or Medicaid/Medi-Cal. This notice must be provided 15-45 days before the individual's premium assistance expires.

- **Optional: If the employer permits individuals to change COBRA coverage options to a less-rich plan, individuals must be provided with a notice to do so**. Individuals have 90 days to elect to change their coverage after notice is provided. This is included as addendums to the model notices linked above.

As of this article's publishing date (04/13/2021), there is a **special notice for mini-COBRA (Cal-COBRA)**, since its administration is different from Federal COBRA's administration. Cal-COBRA is generally administered by carriers. It is unclear how these notices are to be distributed for Cal-COBRA. We are awaiting further regulation and detail from carriers.

Model notices are available for use, and employers must include detailed information such as: the forms necessary for establishing premium assistance; contact information for the plan administrator (employer); a description of the election period; a description that AEI must notify the plan administrator if offered alternate group coverage or eligible for Medicare; a description of the right to receive premium assistance and conditions for entitlement; and, if offered by the employer, a description of the option to enroll in a different coverage option available under the plan.

The subsidy is only available April 1, 2021, through September 30, 2021.
An AEI will not be refunded payment for COBRA premiums before or after the subsidy period. The regulations remind Americans that individual coverage on a state Exchange cannot generally be terminated retroactively, and only can be done prospectively.

The regulations and model notices direct whistleblowers to contact the Department of Labor.
The Department of Labor has released a form for persons to request treatment as AEIs by current/former employers/plan sponsors – if applicable.

Throughout the required employer notices, there are several mentions of contact points for whistleblowers to contact the Employee Benefits Security Administration (EBSA),

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COIN COMPLIANCE CORNER

What Agents and Your Clients Need to Know!

HIPAA Privacy & Security Enforcement Updates—

By: Dorothy M. Cociu, RHU, REBC, GBA, RPA, LPRT

Although there have been no HIPAA Privacy & Security HHS/OCR settlements or Civil Monetary Penalties (CMPs) since the last issue, there has been a lot of activity from HHS and OCR over the past two months.

45-Day Extension to the Public Comment Period for Notice of Proposed Rulemaking

On March 9, 2021, the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) announces a 45-day extension of the public comment period for the Notice of Proposed Rulemaking (NPRM) to modify the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

OCR first released the NPRM to the public on the HHS website on December 10, 2020, and it was published in the Federal Register on January 21, 2021. The 45-day extension moves the current deadline for the public to submit comments from March 22, 2021, to May 6, 2021. The notice of extension of the comment period is available at https://public-inspection.federalregister.gov/2021-05021.pdf.

The proposed changes to the HIPAA Privacy Rule include strengthening individuals' rights to access their own health information, including electronic information; improving information sharing for care coordination and case management for individuals; facilitating greater family and caregiver involvement in the care of individuals experiencing emergencies or health crises; enhancing flexibilities for disclosures in emergency or threatening circumstances, such as the Opioid and COVID-19 public health emergencies; and reducing administrative burdens on HIPAA covered health care providers and health plans, while continuing to protect individuals' health information privacy interests.

OCR encourages and will carefully consider comments from all stakeholders, including patients and their families, consumer advocates, HIPAA covered entities (health plans, health care clearinghouses, and most health care providers) and their business associates, health care professional associations, health information management professionals, health information technology vendors, and government entities.

"OCR anticipates a high degree of public interest in providing input on the proposals because the HIPAA Privacy Rule affects nearly anyone who interacts with the health care system," said Acting OCR Director Robinsue Frohboese. "The 45-day extension of the comment period to May 6, 2021, will give the public a full opportunity to consider the proposals and submit comments to inform future policy."

Interested members of the public may submit their comments on the NPRM no later than May 6, 2021. The NPRM is available for review and comment at https://www.federalregister.gov/documents/2021/01/21/2020-27157/proposed-modifications-to-the-hipaa-privacy-rule-to-support-and-remove-barriers-to-coordinated-care.

Cybersecurity Alert – Microsoft Exchange Vulnerabilities

On March 5, 2021, OCR announced sharing the following Updated Alert on Mitigating Microsoft Exchange Vulnerabilities with our listserv from the Cybersecurity and Infrastructure Security Agency (CISA) to assist HIPAA covered entities and their business associates in addressing serious threats to Microsoft Exchange servers. Organizations are encouraged to review the information below and take appropriate action.

In a prior cybersecurity newsletter (https://www.hhs.gov/sites/default/files/spring-2019-ocr-cybersecurity-newsletter.pdf), OCR provided information on zero-day vulnerabilities.

Additional Resources

https://us-cert.cisa.gov/ncas/alerts/aa21-062a

https://us-cert.cisa.gov/ncas/current-activity/2021/03/04/update-alert-mitigating-microsoft-exchange-server-vulnerabilities

https://cyber.dhs.gov/ed/21-02/

https://msrc-blog.microsoft.com/2021/03/02/multiple-security-updates-released-for-exchange-server/

Update to Alert on Mitigating Microsoft Exchange Server Vulnerabilities

Original release date: March 4, 2021

CISA is aware of threat actors using open source tools to search for vulnerable Microsoft Exchange Servers and advises entities to investigate for signs of a compromise from at least September 1, 2020. CISA has updated the Alert on the Microsoft Exchange server vulnerabilities with additional detailed mitigations.

CISA encourages administrators to review the updated

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Alert and the Microsoft Security Update and apply the necessary updates as soon as possible or disconnect vulnerable Exchange servers from the internet until the necessary patch is made available.

HIPAA Right of Access Initiative

In other HHS/OCR News, OCR recently settled its 17th and 18th investigations into its HIPAA Right of Access Initiative. In the 18th settlement, Village Plastic Surgery agreed to take corrective actions and pay $30,000 to settle a violation of the HIPAA Privacy Rule's Right to access standard, for allegedly failing to take timely action in response to a patient's records access request made in August, 2019.

In addition to the monetary settlement, VPS will undertake a corrective action plan that includes two years of monitoring.

Voluntary Resolution Agreement – Protecting Patients from HIV Discrimination

On March 4th, HHS OCR and the U.S. Attorney's Office for the Eastern District of Michigan Enter Voluntary Resolution Agreement with Michigan Bariatric Practice to Protect Patients from HIV Discrimination.

The U.S. Department of Health and Human Services, Office for Civil Rights ("HHS OCR") and the U.S. Attorney's Office for the Eastern District of Michigan have entered into a Voluntary Resolution Agreement with Great Lakes Surgical Associates ("GLSA") to protect patients from discrimination on the basis of HIV status. The Complainant, an African American man and a Medicare beneficiary, initially filed a complaint with the Department of Justice (DOJ), reporting that his primary care physician referred him to GLSA for bariatric surgery to address his high blood pressure and diabetes. However, GLSA allegedly refused to fully evaluate him for bariatric surgery or to provide him with the surgery due to the Complainant's HIV status.

The U.S. Attorney's Office for the Eastern District of Michigan investigated the allegation that GLSA discriminated against the Complainant based on his disability, in violation of Title III of the Americans with Disabilities Act of 1990 ("Title III of the ADA"). Title III of the ADA prohibits public accommodations from discriminating on the basis of disability in the full and equal enjoyment of their goods, services, facilities, privileges, advantages, or accommodations.

In cooperation with DOJ, HHS OCR initiated a compliance review to determine GLSA's compliance with Section 504 of the Rehabilitation Act of 1973 ("Section 504"), and Section 1557 of the Patient Protection and Affordable Care Act of 2010 ("Section 1557"). Section 504 prohibits discrimination on the basis of disability (including HIV status) in programs or activities that receive HHS funding, such as hospitals, nursing homes, or physician practice groups. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.

The Voluntary Resolution Agreement requires GLSA to:

- Post a Notice of Nondiscrimination notifying GLSA personnel, patients, and the public that it does not discriminate on the basis of race, color, national origin, sex, age or disability, including HIV status, in its health programs or activities;
- Provide assurances that, in the future, it will not discriminate on the basis of disability; nor retaliate against any person who has made, or is making, a disability discrimination complaint;
- Adopt a Grievance Procedure and designate a Civil Rights Coordinator who will investigate grievances or discrimination complaints made against GLSA;
- Establish and implement policies and procedures for providing services in a nondiscriminatory manner to individuals with disabilities;
- Arrange for training of all personnel on GLSA's obligations to not discriminate against individuals with disabilities; and
- Report on implementation of the Agreement for a three-year term.

In addition, pursuant to DOJ's authority under Title III of the ADA, GLSA has agreed to compensate the Complainant in the amount of $37,000.

"The HHS Office for Civil Rights is committed to ensuring that all individuals with disabilities are afforded an equal opportunity to participate in and benefit from health care programs and services," said Acting HHS OCR Director Robinsue Frohboese. "Discrimination against individuals with HIV in health care or human services is unlawful and we will continue to take appropriate steps to remedy discrimination when it occurs and provide consumers with knowledge about their rights and providers with awareness of their obligations."

A copy of the Voluntary Resolution Agreement may be found at: https://www.hhs.gov/sites/default/files/glsa-joint-vra.pdf*.

I will provide additional updates in the next issue! ##

The STATEment

CAHU's Magazine!

Check out CAHU's bi-monthly online magazine at https://www.cahu.org/newsroom.

Legislative Update:

It's Back, Another Attempt at a Single Payer System

By: David Benson - OCAHU VP Legislation

Our Legislative Team in Sacramento states "AB 1400 abolishes private health insurance in California, along with Medi -Cal, Medicare, Covered California, and the valuable advocacy services of health insurance professionals and advisors. Under AB 1400 ALL Californians will lose their current benefit plans, to be replaced by benefits yet to be determined, to be serviced by an entity yet to be identified, to include new tax provisions yet to be detailed. AB 1400 has too many unanswered questions and Californians cannot afford "to pass it to find out what's in it."

The California Association of Health Underwriters (CAHU) agents are on the front lines every day working to preserve choices, improve quality and expand access to health care. CAHU opposes single payer because it creates a government run monopoly that eliminates consumer choices, drives up health care costs and sets back our efforts to increase access to quality affordable health care options for consumers."

Here are some of the key provisions of AB 1400.

This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. Among other things, this bill would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The board would be required to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

CalCare would be governed by a board, the CalCare Board, made up of 9 voting members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The board would be provided with all the powers and duties necessary to establish CalCare, including determining when individuals may start enrolling into CalCare, employing necessary staff, negotiating pricing for covered pharmaceuticals and medical supplies, establishing a prescription drug formulary, and negotiating and entering into necessary contracts. The board would be required to convene a CalCare Public Advisory Committee with specified members to advise the board on all matters of policy for CalCare. An 11-member Advisory Commission on Long-Term Services and Supports would need to be establish, to advise the board on matters of policy related to long-term services and supports.

The health care providers participating in CalCare, would be provided with a participation agreement between a health care provider and the board, listing participation requirements and specifics on payment for health care items and services. Participation providers would be prohibited from discriminating against a person by, among other things, reducing or denying a person's benefits under CalCare because of a specified characteristic, status, or condition of the person.

A participating provider would be prohibited from billing or entering into a private contract with an individual eligible for CalCare benefits regarding a covered benefit, but the bill would authorize contracting for a health care item or service that is not a covered benefit if specified criteria are met. Health care providers would be able to collectively negotiation fee-for-service rates of payment for health care items and services using a 3rd-party representative, as provided. The board would need to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget.

This bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The CalCare Trust Fund would be created in the State Treasury, as a continuously appropriated fund, making an appropriation, consisting of any federal and state monies received for the purposes of the act.

Specified provisions of the act would be prohibited from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human

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It's Back, Another Attempt at Single Payer, cont. from page 10

Services Agency would be required to publish a copy of the notice on its internet website.

As AB 1400 works its way through the legislative process the proponents of the bill will be holding news conferences and writing articles discussing the positives of this legislation. They will be selling the public on the sizzle, but not providing all of the facts. CAHU plans to hold Town Hall meetings throughout California, webinars and write articles detailing the unintended consequences of AB 1400. CAHU will provide its members with talking points that you can share with your clients. Go to www.cahu.org, click on the Legislation link, under "Our Issues" click on AB 1400. All of the information on AB 1400 is behind a password protected firewall which CAHU Members can access.

The proposed 2021 budget for California is 227.2 billion dollars. There is no funding mechanism for AB 1400. The last time a Single Payer bill was proposed in California (a few years ago) the projected annual budget was over 400 billion dollars which is approximately double the state budget. Every person in California would have to pay $20,000 to $24,000 in additional state tax to get free insurance.

With the exception of Hawaii every state that set up a single payer healthcare system almost went bankrupt. Vermont voters approved a single payer system a few years ago. The liberal Democratic Governor signed the bill into law. The Governor could not implement the single payer system because of the cost. It was unaffordable.

Another discussion topic is rationing of care. In the Canadian healthcare system if you are 70 years old you cannot get a heart bypass surgery. People over the age of 52 could not get kidney dialyses. Hospitals were given a budget. If the budgeted money ran out in October the hospital shut down until the end of the year. Imagine being on a waiting list for many months to have surgery and just prior to the scheduled surgery date the hospital shuts down. Under our current healthcare system you can schedule the same surgery within one or two days.

Prior to the implementation of ObamaCare we faced 2 major issues with the old healthcare system, access to care and the rising cost of healthcare. Access to care was addressed under the ObamaCare system. The rising cost of healthcare has never been addressed. Until Congress takes steps to control the rising cost of healthcare premiums will continue to increase and healthcare will become unaffordable.

Less than 1% of the members of Congress and the California State Legislature worked in the healthcare field prior to getting elected. A large majority of those folks were doctors or nurses. Our industry is very complex. As well intentioned as legislators are in introducing new healthcare legislation there are always unintended consequences. A small percentage of legislators are willing to work with our industry to create legislation without unintended consequences. The majority of legislators believe they know more than we do even though they never worked in our industry.

Your contributions to CAHU-PAC and HUPAC are very important. PAC contributions grant us access to legislators. Our job is to educate legislators so they ask for our assistance in crafting language for healthcare bills and they ask the right questions of the bill's author as bills work there way through the legislative process. Over the years we have been successful in adding amendments to bills to improve them and killing bad healthcare legislation.

##

COBRA Subsidy Update—ARP, cont. from page 7

which also oversees enforcement of ERISA law, if they feel they are AEIs, but are not being treated as such.

Noncompliance penalties are steep.
The regulations clarify that employers will be subject to tax penalties of $100/employee **per day** for violations of notices under ARP. The penalty rises to $200/employee/day for employees with one or more dependents. However, the enforcing Departments understand that new ARP changes are challenging; they are considering good-faith efforts to comply with ARP before assessing potential penalties.

In COBRA, however, civil penalties (lawsuits filed by employees against employers) often carry the greatest liability and biggest exposure in the compliance space for employers.

How will carriers handle this for Cal-COBRA?
As of this article's publishing, there are still many outstanding questions about the administration of ARP law. Regulations specify that mini-COBRA applies under ARP, but it is unclear how it will be administered. Cal-COBRA is generally administered by the carrier, and direct-billed to the COBRA participant. Federal COBRA is administered by the employer, and premiums are usually included on the employer's monthly premium statement. ARP law says employers must forward payment for AEIs' COBRA premiums so the IRS can subsidize them, but how that will work in Cal-COBRA is still unclear. Further regulations are expected to be released over the coming weeks, and additional information from carrier partners will follow.
##

May Meeting: CE Webinar

May 11, 2021

NAHU Washington Update: Political and Judicial Outlook, Omnibus Package

(1-HR CE | Course Pending Approval)

Tuesday, May 11, 2021 | 12 to 1 PM

Cost to Attend: Member $0 | Non-Member $10

In this session, Janet Trautwein examines legislative and regulatory actions taken by Congress and federal agencies in response to COVID-19 and the role that NAHU is having in this process; Outlook on the first 100 days of a new administration; priorities for the new 117th Congress; Implications of 50-50 Senate; major regulatory actions that have been taken and are expected in the near-term and later; and how NAHU members, the overall agent/broker community, and employers can get involved.

Upon completion of the course, the participant will know:

- The political basis for how policymaking may be affected as the result of COVID-19, including NAHU's strategies to achieve policy goals;
- Specific policy proposals that have been and are under consideration or are being developed by Congress and the Administration;
- The political background, changes and processes that are leading to particular actions being made and how NAHU works to influence these processes;
- Policy positions of the association in affecting change in health reform at both the legislative and regulatory levels and how those positions are developed;
- Tools and resources for becoming active and engaged in these processes.

REGISTER NOW at ocahu.org

About the Speaker:

Janet Trautwein

Executive Vice President & CEO| National Association of Health Underwriters (NAHU)

Janet Trautwein is the chief executive officer of NAHU and president of the NAHU Education Foundation in Washington DC. NAHU represents employee benefits professionals involved in the design, implementation and management of health plans all over the United States. Her responsibilities include oversight of all NAHU and NAHU Education Foundation activities, including oversight of 30 staff members in Washington DC and 210 state and local chapters. She is the primary spokesperson for NAHU to the media, government agencies and elected officials at all levels.

A frequent speaker on health-policy issues, Janet's expertise in issues related to health insurance markets, the uninsured, risk and reinsurance pooling, benefits-related tax and tax-preferred account issues, and both national and global health reform has been recognized throughout the industry. Janet has testified before Congress numerous times, has been published in major news outlets, and has appeared on hundreds of radio and television programs around the world.

Janet holds a degree in government and international affairs from George Mason University, where she graduated summa cum laude, and a master's degree in health economics, health policy and health management from the London School of Economics.

##

POP Plan Documents & Renewals

By: Paul Roberts - OCAHU VP Professional Development & CAHU VP of Public Affairs

Employers commonly allow employees to fund their portions of health premiums – that is, their employee contributions – with pre-tax dollars. This feature is so common that many employers (incorrectly) assume they are automatically privileged to utilize pre-tax dollars to fund benefits, just by sponsoring a health plan alone.

While there is some work involved in attaining permission from the IRS to utilize such pre-tax dollars for employee contributions, it is relatively simple for employers to do so. Employers must establish a "Premium Only Plan" (POP), which is sometimes called a "premium conversion plan," in order to utilize this pre-tax option. Employers are prohibited from utilizing tax-free funds from employees' paychecks to fund employee benefit contributions without a POP in place.

In order to establish and implement a POP, employers must adopt a written "plan document" for the POP. This plan document governs the administration of the POP, and includes details about the compliance items required by the IRS for employers' POPs.

What details are in a POP plan document?

Under its rules, IRS generally requires employee plan elections under a POP to be "irrevocable" – meaning employees' plan elections cannot be changed, altered, dropped, etc., until the conclusion of the plan year – unless an employee experiences a change-in-status event such as marriage, divorce, change in dependent status, Medicare entitlement, etc. The IRS also requires employers to conduct testing to satisfy nondiscrimination requirements related to the benefits and contributions provided through the plan. The scope of these details must be included in the POP plan document.

The POP plan document also outlines eligibility for the employer's POP, including information on the benefits offered, participation eligibility, how benefits are funded, the frequency of benefit funding, and other legal notices. And of course, the employer's own tax ID information, etc., is included in the plan document as well.

How does an employer establish a POP and the required documentation?

When employers establish a POP, they usually utilize a POP Third Party Administrator (TPA) to help create the required plan documents. After the first year, a POP renewal is generally sent to the employer – and many employers ask if paying the fee to update the plan document is necessary. While there is no specific language in the Internal Revenue Code Section 125 that requires an employer to pay to renew its POP, the law does say that the plan must comply with the IRS rules and documentation requirements at all times. This means the employer must conduct nondiscrimination testing annually to ensure compliance, and keep plan documents up to date. The renewal fee most POP TPAs charge includes the annual nondiscrimination testing and POP Plan Document compliance review – though all TPAs have different practices and packages. The employer's TPA should be consulted for detail in this area.

Does an employer need to update its POP Plan Document after the plan is established?

Yes. Employers must keep their POP plan documents up to date, as required by the law. It is critically important for the employer to follow all the rules contained in its plan document(s). If the employer fails to operate the plan according to its own rules (and the rules required by the IRS) as described in the plan document, then the tax-advantageous status of the plan could be lost. If this happens, pre-tax benefits could be disallowed retroactively back to the beginning of the plan year. This could require the employer to pay back-taxes, plus interest… and can bring potential noncompliance penalty assessments by IRS and/or Employee Benefits Security Administration (EBSA) for violations of tax law and/or ERISA law. This can also have implications on employees' personal taxes, payroll, and more. It's important for employers to seek legal counsel and/or qualified guidance from a tax professional in these tax-related matters.

A failure to conduct annual nondiscrimination testing to ensure compliance with nondiscrimination requirements could also cause the plan to lose its tax-advantageous status.

What potential occurrences would require a POP Plan Document to be updated?

The employer should annually review its POP plan document for compliance with all IRS laws, ERISA laws, other related laws, and its own policies. This review is most commonly conducted with the POP TPA (usually as part of the paid renewal fee), but can also be facilitated separately by a benefits attorney and/or qualified taxperson. If changes are made to the employer's plan offerings, employer/employee contribution scenarios, funding frequency, employee eligibility, plan effective date, etc., then the plan document must generally be updated to reflect such changes.

Continued on page 15

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Contact Information

EXECUTIVE BOARD

PRESIDENT
MaryAnna Trutanich
Kaiser Permanente
Tel: (626) 824-8962
maryann.m.trutanich@kp.org

PRESIDENT-ELECT
Jo Ann Vernon
BXA
Tel: (720) 989-4950
jvernon@bxall.com

IMMEDIATE PAST-PRESIDENT
Ryan Dorigan
Tel: (951) 422-7005
ryan.dorigan@gmail.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 & SENIOR SUMMIT 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
John Evangelista, LPRT
Colonial Life
Tel: (949) 452-9206
John.evangelista@coloniallifesales.com

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

VP of PROFESSIONAL DEVELOPMENT
Paul Roberts, BBA
Word & Brown
Tel: (800) 869-6989
proberts@wordandbrown.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

MEMBER RETENTION
Gonzalo Verduzco
Word & Brown
Tel: (714) 345-2558
gverduzco@wordandbrown.com

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

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

SOCIAL MEDIA
Brett Buettner
Buettner Insurance Agency
Tel: (714) 377-0600
brett@biabenefits.com

CORPORATE CHAIR
Jim Douglas
Health Sync Insurance
Tel: (714) 222-2411
jim@healthsyncinsurance.com

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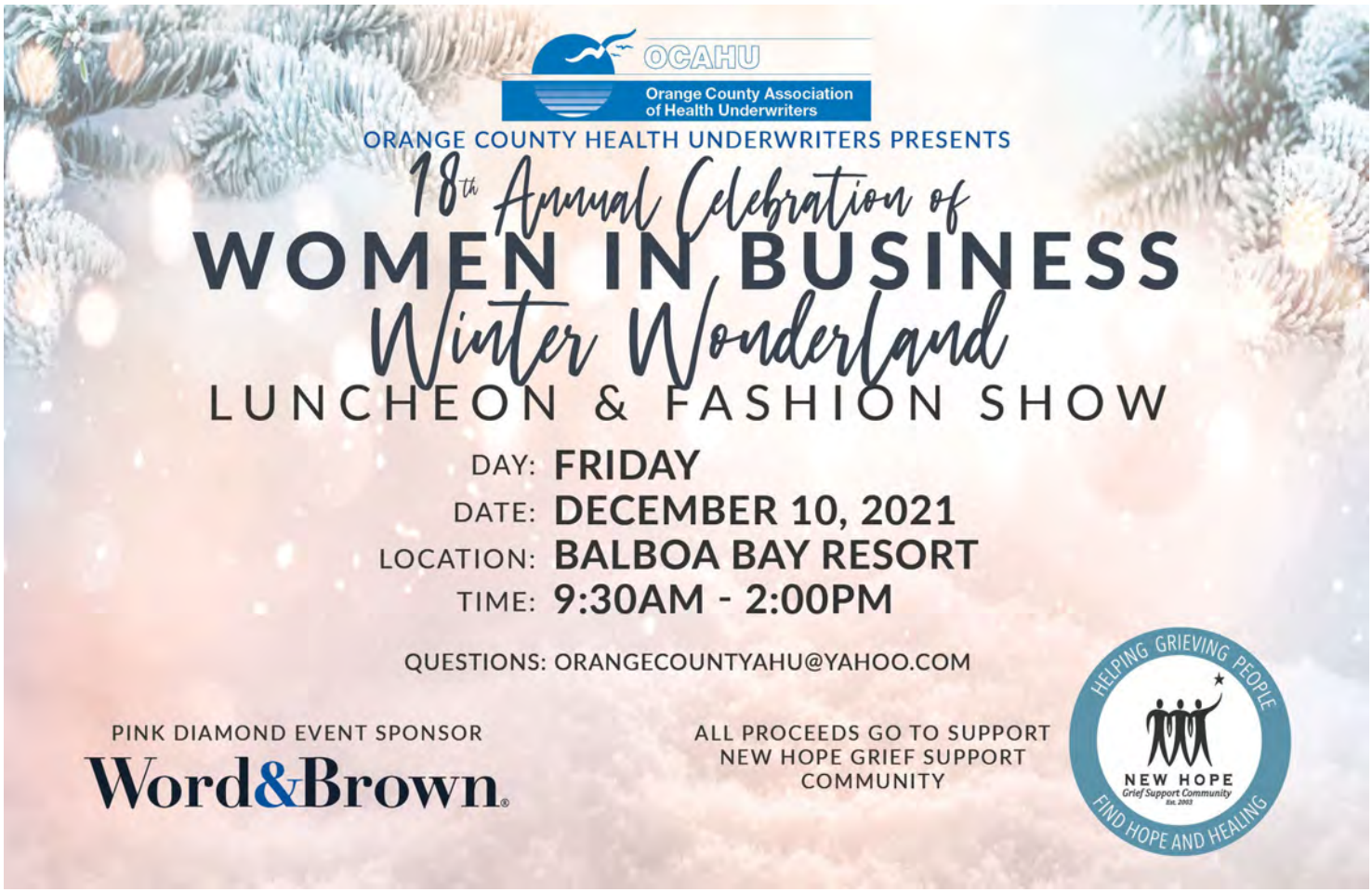
- *Learn more about our industry*
- *Become a better consultant to help your clients*
- *Network with professionals in all areas*
- *Be a resource to your colleagues*
- *Make an impact with legislation*



POP Plan Documents & Renewals, cont. from page 13

If there are regulatory changes that affect POP and benefit eligibility, then the plan documents must be updated as well. For example, when the Defense of Marriage Act (DOMA) was overturned in 2015, plan documents for many employers' POPs were automatically out of date. When DOMA was ruled unconstitutional, any two persons could legally wed irrespective of gender. Previous plan documents that outlined benefit eligibility according to former DOMA law – marriage between a man and a woman only – were out of date, due to conflicts with the change in legislation.

An employer must also update its plan documents if it has a change in name, tax ID, etc.

COVID-19 changes have caused many POP plan documents to become out of date, or in need of update.

Because of the pandemic, various congressional relief was provided to citizens and businesses throughout the country. Part of this congressional relief gave employers a temporary option to allow employees to break the longstanding "irrevocable election" rule in their POPs – giving them the ability to add, drop, increase, or decrease coverage due to the unforeseen challenges of the pandemic. If an employer adopted this option, then its plan documents must be updated to reflect such changes.

When those temporary allowances expire (either by the employer's own accord, or by the IRS itself), plan documents will need to be updated once more.

Ultimately, it is the employer's responsibility to ensure its POP meets IRS compliance. POP TPAs will help employers with annual POP plan document review, and related annual required nondiscrimination testing – usually in exchange for an annual renewal fee, which is paid by the employer to the POP TPA.

As a reminder, it is very important for employers to seek counsel from a qualified attorney, CPA, or tax person for any tax-related matters. Health insurance brokers should tread lightly when giving tax advice, as most insurance brokers' errors and omissions coverage does not cover errors or omissions in tax-related matters. ##

Subscribe to NAHU's Healthcare Happy Hour

http://nahu.org/resources/publications/podcasts

OCAHU Virtual Sales Symposium

By: JoAnn Vernon - OCAHU President Elect

Our theme for the 2021 Annual Symposium was Navigating the New Normal. If we've learned anything over the last year, we must learn to pivot, adapt and continue moving forward. We were able once again to bring together a great slate of speakers that could educate us on Group Benefits, Medicare as well as a Legislative update. During the 2-day event, our attendees were able to earn up to 7 total CE's (thank you Word & Brown for sponsoring). Although we had technical difficulties in bringing our Key Note speaker, Russell Lehmann, to the stage, we were able to host him during the following month's member meeting.

I would like to personally thank our sponsors and exhibitors. Without their participation, it would be impossible to attract the speakers and provide the venue for our membership (thank you Blue of California for sponsoring). Thank you PrimeCare and United Healthcare for providing our coffee, yummy Starbucks. I enjoyed the lunch that was provided by AGA. It is always nice to be able to order exactly what you want. A huge thank you to our Platinum Sponsor, Careington, Gold Show Sponsor, Select HCM and our Silver Sponsor, Senior Market Sales, for everything that you do to support our chapter and membership.

Did you participate in Scavenger Hunt (thank you Dickerson for sponsoring)? It was fun and a way to break up the day and learn more about our exhibitors by hunting for those QR codes. Retire with Renewals was our Grand Prize sponsor, who doesn't love to win $$.

Thank you to our membership for attending and trusting us to continue to provide relevant and up to date topics. We've definitely been Navigating the New Normal and even after the symposium, we had even more legislative changes. It is important that we continue to support one another, and who better to learn from than your peers!

##

Changes to ACA and COBRA Subsidies Go into Effect

By: David Benson - OCAHU VP Legislation

The following article is posted on NAHU's Washington Update: Click Link to Article

Major changes to the ACA marketplace subsidies included in the American Rescue Plan Act (ARPA) went into effect yesterday, along with an increase in federal subsidies for COBRA premiums to 100 percent.

As of April 1, premium tax credits are now available to those with incomes above 400 percent of the Federal Poverty Level for 2021 and 2022, effectively eliminating the ACA's "subsidy cliff" during that time period. Also effective April 1 is the provision of ARPA that reduces the level of income that individuals must contribute toward their premiums. For individuals who received, or are approved to receive, unemployment benefits this year, their income will be treated as no higher than 133 percent of the FPL. However, those benefits did not go live on April 1, and instead will begin in early July.

For new consumers enrolling for the first time on or after April 1, the process is the same: Complete the application, receive an eligibility determination, select a plan and pay the first month's premium (with the option of receiving PTCs in advance). Those who enrolled prior to April 1, however, need to return to HealthCare.gov and update their application to receive new eligibility results, and decide how they want to use the additional tax credits allotted by ARPA. If a current enrollee does not claim their enhanced PTCs, those credits will be reflected in their 2022 taxes.

HHS announced this week that it will spend an additional $50 million in advertising to bolster this SEP through August 15. HHS hopes this advertising will entice uninsured consumers, gig workers who may have experienced a reduction in hours, those who have lost coverage in 2020 or 2021, and consumers who may be newly eligible for financial assistance and PTCs. As a reminder, if you work with clients in the individual market who now qualify for subsidies on the exchange, you can still complete the HealthCare.gov agent/broker registration and training for plan year 2021 in order to help consumers take advantage of the SEP to enroll in 2021 coverage on the exchange. CCIIO has this resource available to help you understand what steps you need to take to complete registration and training in the Marketplace Learning Management System.

We are still awaiting guidance from federal agencies regarding specifics surrounding ARPA's changes to COBRA subsidies. There are still many outstanding compliance questions, as NAHU has outlined in recent webinars and podcasts. Specifically, the Treasury Department may permit an advance credit for employers, while the Department of Labor is expected to issue model COBRA notices addressing the subsidy. As always, NAHU is monitoring pertinent regulatory developments. ##

CBO Releases Report on Public-Option Proposals Prior to Congressional Democrats Reintroduction of the Choose Medicare Act

By: David Benson - OCAHU VP Legislation

The following article is posted on NAHU's Washington Update: Click Link to Article

Senators Dianne Feinstein (D-CA), Chris Murphy (D-CT) and Jeff Merkley (D-OR) introduced the Choose Medicare Act this week, yet another attempt at implementing a public option at the federal level. This is not the first time that the Choose Medicare Act has been introduced, and it will likely not be the last. Ironically, the Congressional Budget Office (CBO) released a report just days before the bill was introduced detailing the negative consequences of a public option on the health insurance market.

While most public-option proposals we have seen are primarily aimed at providing coverage on the individual market, the Choose Medicare Act would also involve the employer-sponsored market. The bill would create Medicare Part E, a new plan that would be made available to all individuals on the ACA exchange. But it would also make the public option plan available to all sizes of employers as a potential substitute or supplement for private insurance for their employees. Under this legislation, ACA enrollees who receive subsidies would be able to put those subsidies towards buying into the Medicare Part E plan. If even just a small number of major employers elected to participate, hundreds of thousands of households could transition to this public option.

NAHU is committed to preserving market stability. The pandemic has led to a growing interest in expanding access to coverage through some version of a single-payer healthcare system through incremental approaches such as a public option, a Medicare or Medicaid buy-in, or a more sweeping federal takeover of the entire healthcare system to implement a single standardized government-run plan. While sweeping legislation like Medicare-for-All cannot garner widespread support among Democrats, a more incremental proposal like this one is often more enticing to moderates. Some public-option bills can sound far more alluring when utilizing current markets such as the Medicare program, which is very popular among beneficiaries, and the employer-sponsored market, from which over 180 million Americans receive their coverage. However, we know that such a plan would destabilize both markets.

Shortly prior to the reintroduction of the Choose Medicare Act, the CBO released a report analyzing design various considerations for a public option and what impacts a public option could have on the market. The results of the report are in line with what we would expect from any legislation utilizing a public option: disruption of coverage, increased premiums, fewer coverage choices, and decreased access to care for seniors and low-income families. The report states that implementing a public option would likely lead multiple private carriers to exit the market entirely.

While the CBO report does not specifically analyze the design of buy-in proposals, it does discuss the implications of employers offering a public option plan. "If employers offered the public option and it paid providers lower rates than private insurers paid, the public option's impact on healthcare providers' revenues would also be greater than if the public option was available only in the non-group market," the report states. "Consequently, providers would be more likely to opt out of Medicaid and Medicare if participation in the public option was tied to those programs."

The argument that proponents of the public option use is that the ACA marketplace and employer-sponsored coverage have not risen to meet the demands of consumers. However, with the recent passage of the American Rescue Plan Act, the ACA's subsidy cliff has been temporarily eliminated and 3.7 million more Americans are now eligible for marketplace subsidies. Additionally the latest polling indicates that most Americans oppose moving to a single-payer or public-option system and the vast majority of consumers with employer-sponsored insurance are satisfied with their coverage.

##

Contact:

John Evangelista

☎ (949) 452-92019

✉ john.evangelista@coloniallifesales.com

NAHU 2021 Capital Conference

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

This year's Capital Conference was virtual. Historically, this National Conference brings the entire country together where members of all NAHU chapters travel to Washington DC to meet with legislators. It is always an exciting time for our members, as we have a platform to speak on pertinent issues that affect our industry. NAHU does a great job of outlining the talking points and educating members who have meetings scheduled on what they will need to focus on when discussing issues with legislators. Our goal is not to be political, but to speak on behalf of the public regardless of party affiliation.

Our Legislative Chairs in each chapter are responsible for setting up appointments and assigning them to lobbyist. Throughout the week, our members met with their local members of Congress virtually and discussed this year's four main talking points below. Meetings usually last anywhere from 20 to 30 minutes. Typically, there are 4 or 5 of us from NAHU in the meeting. There are times when the meeting is with the actual legislator or it could be with his direct assistant. My group met with Mike Levin's office this year.

The first thing we usually discuss is the role of the agent. We try and educate them on what we do and how we impact their constituents. Sometimes our role is misconstrued and thought of as transactional. We want to make sure they understand how high touch we truly are and how much interaction we have with the public. We also offer our assistance should they have any constituents with claims issues where we could intervene.

After introductions, we get right in to our talking points – see below.

2021 Talking Points:

Covid 19 Relief

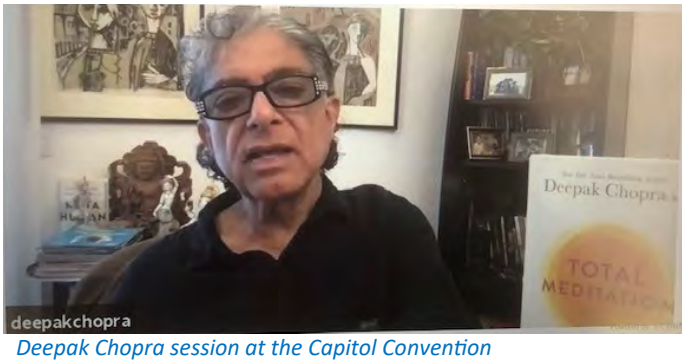
Two major areas of concern with Covid relief were Employer Reporting and PPP Loans.

- **Employer Reporting:** Covid put a huge strain on employers both with the pandemic and stay at home orders. Many employers had to make cuts in their workforce which results in reporting being more cumbersome. Some companies now have variable hour employees for the first time, and they are not used to having that level of complexity to report their ACA affordability. Our ask is that Congress consider suspending enforcement of reporting or providing a safe harbor during the pandemic to help relieve stress and financial burden for our clients.
- **PPP Loans:** PPP loans have greatly assisted in allowing employers to remain in business and maintain coverage for their employees during the pandemic. We asked that Congress consider extending the PPP program to help these business stay afloat longer and employees keep coverage in force during a time where benefits are needed the most.

Market Stabilizers

We strive to help stabilize the market and keep costs down as much as possible for all. The cost for coverage rises every year and can get to a point where it is no longer sustainable. There are four major areas where we believe will help the market stabilize.

- **Employer Exclusion:** Employers and employees receive a tax benefit for benefits offered within their company. With 175 million employees receiving benefits through their employer, it is critical that the tax benefits remain as an incentive for employers to offer coverage. Although employers subject to ACA have to offer coverage, for those employers who are below 50 it is optional. The pre-tax benefit is the largest tax cut for middle class Americans. Removing the exclusion would make healthcare more expensive, thus destabilizing the market and cutting the level of participation.
- **Employer Reporting:** We propose that reporting be done on a prospective basis rather than after the year is completed. This would eliminate the need to collect dependent data that is often difficult to obtain. Easing the reporting provisions would alleviate stress from employers and provide more support for employer sponsored coverage.



Deepak Chopra session at the Capitol Convention

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New Legal Guidance and Resources to Ensure and Expand Access to COVID-19 Vaccines for People with Disabilities and Older Adults

By: Dorothy M. Cociu, RHU, REBC, GBA, RPA, LPRT

The following article is posted on HHS.gov website: Click Link to Article

As part of a shared commitment to President Biden's National Strategy - PDF and Executive Order to ensure an equitable COVID-19 response, the Office for Civil Rights (OCR), the Administration for Community Living (ACL), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS) have published several new resources to help states, vaccination providers, and others leading COVID-19 response activities improve access to vaccines for people with disabilities and older adults. These resources clarify legal requirements, illustrate some of the barriers to vaccine access faced by people with disabilities and older people, and provide strategies – and examples of how the aging and disability network can help employ them – to ensure accessibility.

The Office for Civil Rights released new guidance - PDF* outlining legal standards under the federal civil rights laws prohibiting disability discrimination and providing concrete examples of the application of the legal standards in the context of COVID-19 vaccine programs and how to implement them. OCR also issued a fact sheet - PDF* setting out specific steps that those involved in the planning and distribution of vaccines to combat the COVID-19 pandemic may wish to consider to promote compliance with disability rights laws and provide access to vaccination programs for people with disabilities. Earlier COVID-19 guidance from OCR addressed civil rights protections prohibiting discrimination on the basis of race, color, national origin - PDF, and civil rights of persons with limited English proficiency - PDF.

"Throughout the pandemic, the Office for Civil Rights has made clear that civil rights laws remain in effect during emergencies - PDF," said Acting OCR Director Robinsue Frohboese. "These long-standing laws require that people with disabilities have equal access to services funded by HHS and today's guidance, along with other important resources from our HHS partners, will help providers ensure compliance with their obligations to make vaccinations fully accessible at every step in the process – from public education to registration for appointments and vaccine administration."

The Administration for Community Living has compiled strategies and best practices for helping people with disabilities and older adults access COVID-19 vaccines. This compendium provides creative approaches to outreach and education, appointment facilitation, ensuring website and vaccination site accessibility, and reaching people who cannot be vaccinated outside of their homes. Also included are examples of how the aging and disability network have collaborated with state agencies at virtually every stage of the vaccination process to ensure access for people with disabilities and older adults.

"Vaccination is critical for people with disabilities and older adults, but many face significant barriers to getting vaccinated," said Alison Barkoff, Acting Administrator of ACL. "It is crucial that states and local health authorities take affirmative steps to ensure equitable vaccine access to older adults and people with disabilities, particularly those who may face additional barriers due to race, ethnicity, income, language, or other factors. The organizations in the aging and disability network can be invaluable partners in these efforts."

As trusted members of their communities, the aging and disability network offers unique and specialized knowledge of the needs of the people they serve, as well as established channels for reaching them. Through a partnership between ACL and the Centers for Disease Control and Prevention, the network will receive nearly $100 million to assist with scheduling of, and travel, to appointments, direct support services, and more. The grants also will enable the aging and disability network to identify people who cannot travel to vaccination sites and to assist local authorities with improving vaccine access for people with disabilities and older adults. Funding is being distributed now, with initial grants issued last week.

Finally, the Office of the Assistant Secretary for Planning and Evaluation published an issue brief - PDF on the prevalence and characteristics of older adults who are normally unable to leave home unassisted and for whom leaving the house would take considerable and taxing effort. This will inform the development of interventions to increase vaccination of this population, which has proven challenging to reach thus far.

"Older adults who have difficulty leaving their homes may have a hard time getting to vaccine sites in their communities," said Rebecca Haffajee, Acting Assistant Secretary for Planning and Evaluation. "This brief identifies the characteristics of these individuals, additional challenges they may face when trying to get vaccinated, and what services they use to help communities and providers better target their outreach and in-home vaccination efforts."

About the HHS Office for Civil Rights

The Office for Civil Rights (OCR) enforces federal civil rights laws, the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, and

Continued on page 21

the Patient Safety Act and Rule, which together protect fundamental rights of nondiscrimination and health information privacy. OCR is available to provide technical assistance on federal civil rights requirements and also investigates complaints alleging discrimination on the basis of disability with regard to access to vaccines.

About the Administration for Community Living

The Administration for Community Living (ACL) was created around the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and with the ability to participate fully in their communities. By funding services and supports provided by networks of community-based organizations, and with investments in research, education, and innovation, ACL helps make this principle a reality for millions of Americans. To learn more about the work ACL and the disability and aging networks are doing to combat the pandemic, visit ACL's COVID-19 website.

About the Assistant Secretary for Planning and Evaluation (ASPE)

The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of the Department of Health and Human Services on policy development in health, disability, human services, data, and science; and provides advice and analysis on economic policy. The ASPE leads special initiatives; coordinates HHS' evaluation, research, and demonstration activities; and manages cross-HHS planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, the ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by HHS or Congress. More about how ASPE is supporting COVID-19 response can be found on the ASPE website.

* People using assistive technology may not be able to fully access information in these files. For assistance, contact the HHS Office for Civil Rights at (800) 368-1019, TDD toll-free: (800) 537-7697, or by emailing OCRMail@hhs.gov. ##

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Are you contributing to CAHU-PAC?

This is a pivotal year for our industry. Consider contributing so your voice can be heard at our state's capitol. CAHU-PAC is working for your best interest and those of your clients.

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

CAHU today!

Thanks for your participation!

CAHU Podcast Series

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

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.

- Rethinking Your Insurance Sales Pitch for 2021
- Voluntary Benefits Trends and COVID-19 Impact on Benefits
- 2021 SMB Benefits & Employee Insights Report

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

Membership News

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

Paul Finchamp

Jane Murata

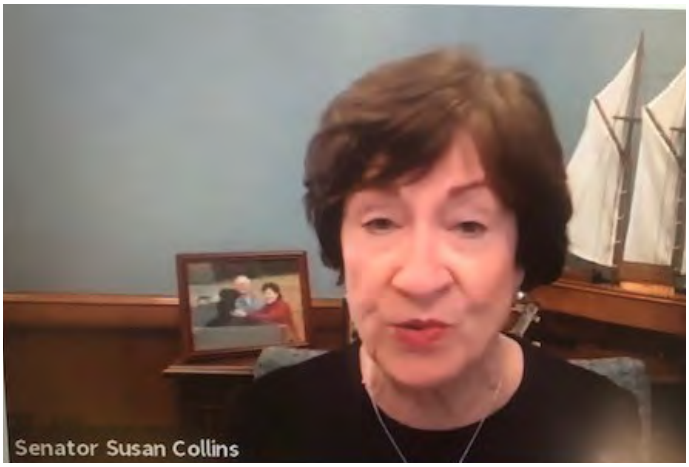
Michael Rankin

- **Prescription Drugs:** The soaring cost of prescription drugs is a big contributor to the cost of healthcare. Bringing down prescription costs would in turn help in bringing down overall medical costs. Allowing for less red tape when new drugs are introduced to the market would drive competition, thus bringing down costs.
- **State Exchange:** Many employers cannot afford to provide contributions for dependent coverage, thus making coverage unaffordable. Currently, if an employee is eligible to receive affordable coverage, the affordability extends to their dependents and does not allow them to obtain subsidies on the exchange. Fixing this glitch will allow dependents to potentially qualify for subsidies and access affordable coverage while decreasing reporting for employers.

Public Option & Medicare for All

NAHU strongly opposes all forms of single-payer healthcare and is committed to promoting employer-sponsored health coverage and preserve Medicare, Medicaid, and other existing health programs. Both Public Option and Medicare for All would put employer sponsored coverage and private insurance in jeopardy.

- **Public Option:** A Public Option would allow Americans to buy-into a government run program. Leading proposals for a Public Option would make it available on state or federal exchanges and pricing would be established according to state or federal marketplace rules. The main concern with a Public Option is the potential to have dramatic cost increases. Providers would need to accept lower reimbursement rates, which could in turn cause providers to exit the market, close down or eliminate some of the services offered to patients. Scarcity of providers will not only affect quality of care, but increase waiting periods or distance to obtain specific services.



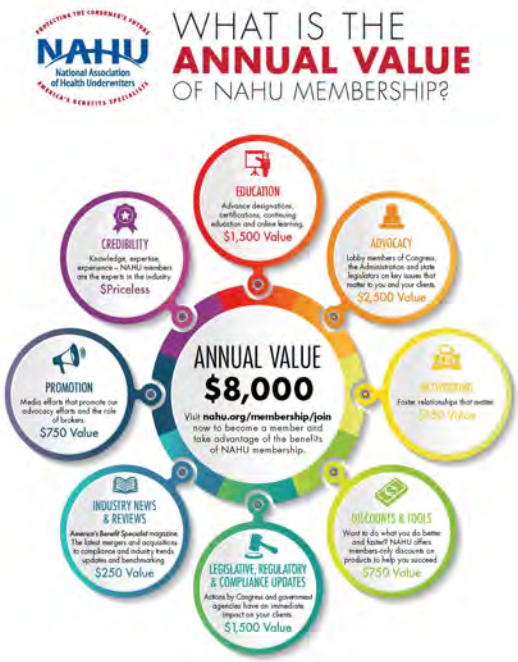
Senator Susan Collins (R-ME) speaking at the Capitol Conferance

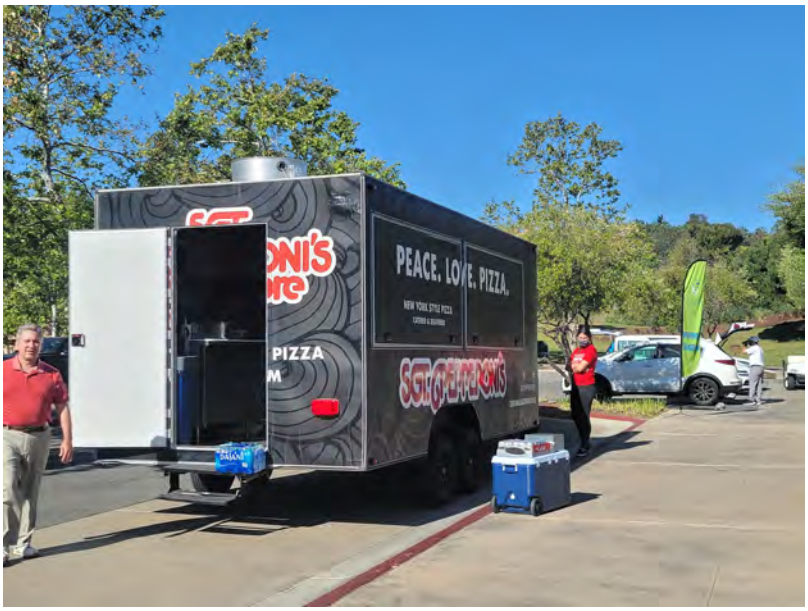
- **Medicare for All:** The implementation of this program would eliminate private insurance, taking away choice from consumers. Funding this type of program would cost an additional $24,000 per household. With the Medicare system already strained, passing a law like Medicare for All would further strain the system and make it unsustainable. Many providers may not be able to afford accepting Medicare rates (which are lower than private insurance), which would potentially make them pull out of the market and cause a shortage of good doctors. Less doctors and/or providers will cause an increase to prices, delayed care, trouble accessing care, and compromise quality.

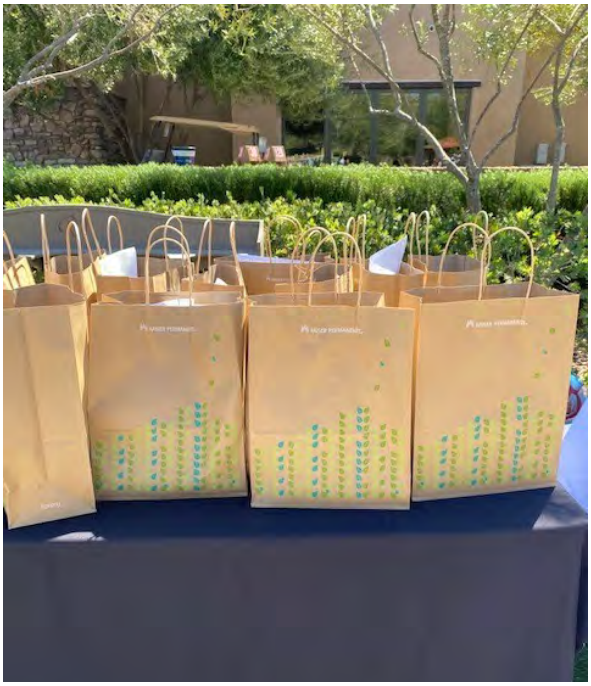
Medicare

Americans have come to depend on Medicare as a core financial and health security element in their later years. Two main areas of focus below provisions that could hurt Medicare beneficiaries.

- **COBRA:** As employees remain at work longer than years passed, it is important for seniors to have access to coverage without any penalties when they're ready to move on to Medicare. Currently, if a Medicare-eligible employee retires and decides to remain on their employer's plan through COBRA, COBRA would not be considered creditable coverage. Even though the employee may remain on the exact same plan they had as an active member and that plan was creditable, the simple fact of being on a COBRA plan would make it non-creditable. What this means, if an employee is on a non-creditable plan and transitioned to Medicare, the employee would face a 10% penalty for life on their Part B coverage. With the strain on the Medicare system, it would be more advantageous for employees to remain on their employer coverage for longer. Removing this penalty would encourage employees to stay on employer coverage until COBRA expires. Additionally, may Medicare beneficiaries may not know about this penalty until it's too late. We propose that COBRA benefits count as creditable if the original plan was deemed creditable.
- **Observation Status:** Many Medicare beneficiaries are classified as being on "observation" status rather than a regular hospital stay. In order for patients to qualify for a care at a Skilled Nursing Facility (SNF), they must be hospitalized under an inpatient stay for 3 days. Observation status does not count towards the requirement. Additionally, observation status can result in significantly higher claims than a regular inpatient stay. Since policies are not uniform when it comes to observation status, it could result in higher out-of-pocket expenses for the Medicare participant. Our proposal is to allow observation status to count towards the 3-day requirement for SNF. ##







Golf Tournament Sponsor Photos

New This Month!

Join OCAHU corporate sponsor Zeguro in our first virtual coffee hour! This meeting will take place prior to our monthly webinar and requires a separate link to join.

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PRECIOUS GEM STONE CONTRIBUTION LEVELS

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

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

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

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

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

Please return this PAC Commitment Form to:
Mail: CAHU PAC 2520 Venture Oaks Way, Ste 150, Sacramento CA 95833
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Revised: 10/2019

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Special Thanks to our 2020-21 OCAHU Board Members!

Our new Board of Directors for 2021-22 will take office in July. We thank those board members who are departing for their service and commitment during a such challenging time in our industry.

Ryan Dorigan
Brett Buettner
John Evangelista
Jim Douglas
Paul Roberts

- THE C.O.I.N. -

Please join us at our events!

UPCOMING EVENTS:

May 11, 2021	**NAHU Washington Update: Political and Judicial Outlook, *Virtual***
May 11, 2021	***Zeguro Virtual Coffee Hour, Virtual***
December 10, 2021	***Women In Business, Balboa Bay Club***

Rescheduled Events

Please stay tuned for more information on the events below. They are in the process of rescheduling for new dates.

CAHU Women's Leadership Summit, DATE and LOCATION: TBD