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County of Orange Insurance News

Mental Health Parity Act's Final Rules & The Complexities of NQTLs; What Does it All Mean?

Also inside this issue

- Legal Brief from Marilyn Monahan, Esq.
- Holiday Cruise December 13th
- Pizza Party Happy Hour Event November 15
- Navigating the Ethical Landscape of Cybersecurity And Much More!



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Orange County

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Thank you for being a part of CAHIP-OC!



**Making a Difference in
People's Lives.
One Member at a Time.**

Our association is a local chapter of the National Association of Benefits & Insurance Professionals (NABIP). 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.

Are you interested in advertising in The COIN? We now offer single issue and multiple issue ads for non-sponsors of CAHIP-OC!

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The C.O.I.N.



CAHIP-ORANGE COUNTY PRESIDENT'S MESSAGE

By: Barbara Ciudad

Dear Members,

As we step into the vibrant months of November and December, I want to take a moment to reflect on the spirit of this season and the strength of our community. This time of year brings opportunities for gratitude, celebration, and connection.

In November, we have the chance to express our appreciation for one another and all that we have accomplished together. Let's take this time to acknowledge our collective efforts and the resilience we have shown throughout the year. Join us for a 4th quarter Happy Hour at a local business owned by one of our own on November 15th.

As December approaches, we look forward to festive gatherings and the warmth of the holidays. These moments remind us of the importance of togetherness and support within our community. I encourage you to participate in our upcoming events, share your traditions, and connect with fellow members.

Thank you for your continued dedication and passion. I am excited about what we can achieve together in the coming year and look forward to celebrating this season with all of you.

Wishing you and your families joy and peace during this special time.

Warm regards,

Barbara Ciudad



IT'S A PIZZA PARTY

NOV 15 2024



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NO REGISTRATION AT DOOR

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4TH Quarter Bringing You Down?

JOIN US FOR A NIGHT OF FUN, FOOD AND GOOD COMPANY! November 15, 2024!



Feature Article:

Mental Health Parity Act's Final Rules and the Complexities of the NQTLs; What Does it All Mean?

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

What's all this talk about Mental Health Parity and why is this so important as we close out 2024? It's important because it requires health plan sponsors and issuers (health insurance carriers) to examine their mental health benefits and determine whether it meets the new standards for mental health parity, and to take certain compliance actions in 2025 and 2026, which will be cumbersome, time consuming and in many cases, expensive to administer. Mental health parity is not new... It's actually been around since the 1990s, but became increasingly important beginning in 2008, leading into the CAA's 2021 requirements for enhanced investigations and enforcement in the Federal Departments. The final rules were released in September, 2024, and although somewhat less burdensome than the 2023 proposed rules, they still carry a massive one-two punch and have been and will continue to be a source of migraines for many plan sponsors and issuers. So, is this all new? No, but it may seem that way, and it has never been more important to put time, effort and energy into compliance.

Starting in January, 2025, plan sponsors and issuers are required to follow complex mental health/substance abuse parity when compared to medical/surgical benefits, and comply with disclosure requirements and comparative analysis content requirements. In 2026, additional requirements must be met, including compliance with the meaningful benefits standard, prohibition on certain discriminatory and evidentiary standards, data evaluations requirements and the related comparative analyses requirements. If it sounds a bit complicated, it is.... Some would say a lot more than a bit complicated.... But I'm going to try to break this down and simplify it, as best I can, so that the average plan sponsor and their brokers/consultants can understand it.

A lot of what I'm about to discuss may relate more to the self-funded community, but I think the industry in general, including brokers and consultants, need to be aware of this in the event an employer client asks them about something related to mental health parity. It helps to have a reference article available to review and provide some simple answers, like what certain terms mean. And, similar rules apply to fully insured health plans... the plan sponsor just doesn't have to be directly involved with the compliance and implementation I will be discussing. But if nothing else, everyone in the industry should be aware because laws and regulations have an impact on many things, including potential premium increases, as more administrative and compliance are required whether the employer plan sponsor is self-funded or fully insured. *The last thing any broker*

needs is to have a client ask them what an NQTL is and the broker stares at them with a blank face, clearly indicating that they have no idea what they are talking about. That is embarrassing at best. So, for the sake of keeping your client's respect and showing them that you understand what's happening in the market, and not showing that "oh no, I have no idea" look on your face, it's probably not a bad idea to keep reading, even if today your clients are all fully insured.

The History of Mental Health Parity

Mental health parity, as we know it, actually began in 1996 with the passage of HR 4058, or the Mental Health Parity Act of 1996. This was the first federal law that forced complete parity in mental health plans, to be consistent with medical/surgical benefits that were offered.

In 2008, Congress passed HR 6983, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which is when most of us started paying closer attention to mental health and substance abuse parity requirements. MHPAEA amended the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, and the Internal Revenue Code to require a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits to ensure that: "(1) the financial requirements, such as deductibles and copayments, applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan; (2) there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; (3) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan; and (4) there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits" (Congress.gov; HR 6983, 110th Congress).

MHPAEA also requires "the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services made under the plan with respect to mental health or substance use disorder benefits to be made available by the plan administrator. In addition, it requires the plan to provide

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SAVE THE DATE!

**LEGISLATIVE
UPDATES**

JANUARY 14, 2025

 **11:00 AM – 1:00 PM**

BREA COMMUNITY CENTER

 admin@cahipoc.org

 www.cahipoc.org



*Join Us For
Our Annual
Legislative
Update*

January 14, 2025

11 am—1 pm

Brea Community Center

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(near Birch & Randolph, off the 57 fwy)

Brea, CA

Note: New Location for This Meeting!



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Dr. Sean Hashmi: Kaiser Permanente – Obesity Medicine Specialist

Devin Hughes: Award winning motivational speaker

Phil Calhoun: Owner/Publisher of California Broker Magazine



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TUESDAY | 8AM – 3PM
FEBRUARY 11, 2025



Lake Forest Community Center
100 Civic Center Drive, Lake Forest, CA 92630

Sponsorship Opportunities Available: Contact Admin@CAHIPOC.org



COIN COMPLIANCE CORNER

What Agents and Your Clients Need to Know!

*Featuring Legal Briefs By Marilyn Monahan, Monahan Law Office,
and HIPAA Privacy & Security & Related Updates by Dorothy Cociu,
CAHIP-OC VP of Communications & Public Affairs*



Legal Briefs

The focus of this legal update is new California laws—most effective January 1, 2025—as well as a series of reminders about some upcoming federal deadlines.

FEDERAL: HIGHLIGHTS

2024 Forms 1094/1095: The Internal Revenue Service (IRS) has issued final versions of the 2024 Forms 1094/1095, as well as final versions of the instructions for these forms. “Applicable large employers” (ALEs) must furnish to employees and file the 2024 Forms 1094/1095-C with the IRS by the following deadlines:

The 2024 Forms 1095-C must be furnished to employees on or before March 3, 2025. No extensions will be granted.

The 2024 Forms 1094-C and 1095-C must be filed electronically with the IRS on or before March 31, 2025. (Due to a recent IRS rule change, paper filing is no longer an option for ALEs.) A 30-day extension to file is available if ALEs file a Form 8809 on or before the due date to file.

Small employers with fewer than 50 full-time and full-time equivalent employees and that offer a self-funded plan must also furnish and file the Forms 1094/1095. In that case, the employer uses the B series forms, rather than the C series forms. Remember that a level funded plan is a self-funded plan.

Because California has an individual coverage mandate, the Franchise Tax Board (FTB) needs the Forms 1094/1095 to track who has coverage and who does not. If an employer has a fully insured plan and the carrier files the 2024 Forms 1094/1095-B, the employer does not have to file with the FTB. However, if the employer has a self-funded plan, the employer must file the 2024 Forms 1094/1095-C with both the IRS and the FTB. The FTB’s deadlines are as follows:

The 2024 Forms 1095-C must be furnished to employees by January 31, 2025.

The 2024 Forms 1094-C and 1095-C must be filed with the FTB on or before May 31, 2025 (which is a Saturday). If filing 250 or more forms, you must file electronically.

California is not the only jurisdiction with an individual coverage mandate. Employers with employees in the District of Columbia, Massachusetts, New Jersey, Rhode Island, and Vermont should confirm whether they have any filing requirements in those states

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HIPAA/HHS/OCR Updates

There have been several enforcement activities to report this issue, starting with a report close to many of our hearts and heads in southern California; a Civil Monetary Penalty imposed against Providence Medical Institute.

On October 8, 2024, HHS Office for Civil Rights reported that they had Imposed a \$240,000 Civil Monetary Penalty Against Providence Medical Institute in HIPAA Ransomware Cybersecurity Investigation. *This CMP marks OCR’s fifth ransomware enforcement action amid a 264% increase in large ransomware breaches since 2018.*

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) announced a \$240,000 civil monetary penalty against Providence Medical Institute in Southern California, concerning potential violations of the [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) Security Rule](#), following a ransomware attack breach report investigation by OCR. Ransomware and hacking are the primary cyber-threats in health care.

“Failures to fully implement all of the HIPAA Security Rule requirements leaves HIPAA covered entities and business associates vulnerable to cyberattacks at the expense of the privacy and security of patients’ health information,” said OCR Director Melanie Fontes Rainer. “The health care sector needs to get serious about cybersecurity and complying with HIPAA. OCR will continue to stand up for patient privacy and work to ensure the security of health information of every person. On behalf of OCR, I urge all health care entities to always stay alert and take every precaution and steps to keep their systems safe from cyberattacks.”

OCR enforces the [HIPAA Privacy, Security, and Breach Notification Rules](#), which sets forth the requirements that covered entities (health plans, health care clearinghouses, and most health care providers), and business associates must follow to protect the privacy and security of protected health information. The HIPAA Security Rule establishes national standards to protect individuals’ electronic personal health information that is created, received, used, or maintained by a covered entity. It also requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information. The Civil Money

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they must satisfy. (In past years, each jurisdiction other than Vermont has had filing requirements.)

Gag Clause Attestation: The gag clause attestation—an annual reporting requirement added by the Consolidated Appropriations Act, 2021 (CAA)—is due on or before **December 31, 2024**.

RxDC Reporting: RxDC reporting—an annual reporting requirement added by the CAA—is not due until **June 1**. However, to prepare for compliance, many carriers will send out surveys to their group policyholders early in the new year, and there may be a short timeframe to respond. Employers with fully insured plans should be encouraged to respond to those surveys on time, or they will have to perform at least some of the RxDC reporting themselves.

Mental Health Parity and Addiction Equity Act (MHPAEA) and the CAA: Following changes made to MHPAEA by the CAA, final regulations were recently issued by the Departments of Labor, Treasury, and Health and Human Services (the Departments). Portions of the final rules are effective for plan years beginning on or after **January 1, 2025**, and other provisions are effective for plan years beginning on or after **January 1, 2026**.

Summary of Benefits and Coverage (SBC) and Claim Forms: Revisions: SBCs and claim forms are being revised for 2025. Plans must comply for the plan year beginning on or after **January 1, 2025**.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule: The HIPAA Privacy Rule has been amended. Covered entities and business associates must comply and implement relevant changes by **December 23, 2024**. In addition, Notices of Privacy Practices must be amended by **February 16, 2026**.

Fixed Indemnity Coverage Notice: In March, the Departments issued final regulations on (a) short-term limited duration insurance and (b) fixed indemnity insurance. For plan years beginning on or after **January 1, 2025**, with respect to hospital indemnity or other fixed indemnity insurance, the plan or issuer must display prominently on the first page (in paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time they are given the opportunity to enroll, in at least 14-point type, a specific notice (the notice is included in the regulations)—the notice mandate applies to both individual and group plans. The Departments did not address the tax treatment of this coverage, but may in future rulemaking.

ERISA and Cybersecurity Standards: In 2021, the Department of Labor issued guidance on cybersecurity best practices plans should adopt, including when hiring service providers. Recently, because of confusion over whether the earlier guidance applied to both retirement and health and welfare plans, the DOL updated the guidance and clarified that it does apply to both.

IRS Notice 2024-71: In this notice, the IRS announced that condoms are treated as expenses for medical care, and are therefore reimbursable through a health flexible spending account (FSA), health reimbursement arrangement (HRA), or health savings account (HSA).

New California Laws

Governor Newsom had until September 30th to sign or veto all bills presented to him by the legislature by the last day of session (August 31st). All bills signed by the governor take effect January 1, 2025, unless by their terms they have an earlier or later effective date. The summaries below highlight some of the key insurance and workplace bills signed by the governor (the new state insurance laws do not apply to self-funded health plans):

A.B. 2258 – Cost Sharing: Effective January 1, 2025, insurers/HMOs cannot charge cost-sharing for items or services integral to providing preventive care (applies to non-grandfathered plans). The bill specifies that insurers/HMOs must cover without cost-sharing certain specific items, including cervical cancer screening tests, colorectal cancer screening tests, and home test kits for sexually transmitted diseases.

A.B. 3275 – Claim Reimbursement: Changes rules on amount of time insurers/HMOs may take to process claims. Under the new bill, claims will have to be paid within 30 calendar days. If claims are paid late, the insurer/HMO must add 15% interest and, if they do not, they will owe the greater of an additional \$15 or 10% of the accrued interest.

A.B. 1048 – Dental Coverage: Effective January 1, 2025, dental plans must report certain rate data to regulators. Also, effective January 1, 2024, insurers/HMOs shall not impose a dental waiting period provision in a large group plan or a preexisting condition provision for any plan.

A.B. 3221 – HMO Records: HMOs must maintain records electronically and provide access to the Department of Managed Health Care (DMHC).

S.B. 1120 – Utilization Review: Limits use by insurers/HMOs (including specialized plans) of AI for utilization review or utilization management functions, based in whole or in part on medical necessity. If AI is used, it must satisfy delineated standards. Medical necessity determinations shall be made by a licensed physician or health care professional.

S.B. 729 – Treatment for Infertility and Fertility Services: Effective July 1, 2025, large group plans must cover the diagnosis and treatment of infertility and fertility services (including IVF); for small group plans, insurers/HMOs must offer the option to employers. There is an exemption for religious employers. The law shall not apply to plans/policies issued to PERS until July 2027.

A.B. 2843 - Rape and Sexual Assault: Effective July 1, 2025, insurers/HMOs must cover emergency and follow up care for a participant treated for rape or sexual assault for the first 9 months after treatment is initiated. Plans cannot require the filing of a police report as a condition of coverage.

A.B. 3059 – Human Milk: Insurers/HMOs must cover medically necessary pasteurized donor human milk obtained from a licensed tissue bank.

S.B. 339 – HIV Preexposure Prophylaxis and Postexposure Prophylaxis

Legal Briefs, Continued from Page 9

is: Authorizes pharmacists to furnish up to a 90-day course of specified HIV medicine; these medicines must then be covered by insurers/HMOs.

S.B. 1180 – Emergency Medical Services: Effective July 1, 2025, insurers/HMOs must provide coverage for services provided by a community paramedicine program, mobile integrated health program, and triage to alternate destination program. These programs may be offered by fire departments, but may not be covered by insurance.

A.B. 1870 – Workers’ Compensation: Notice: Employers must post a notice advising employees of their rights under the state’s workers’ compensation system. Effective January 1, 2025, that notice must include information concerning an injured employee’s right to consult a licensed attorney to advise them of their rights under workers’ compensations laws, and that in most instances attorney’s fees will be paid from an injured employee’s recovery.

A.B. 2337 – Workers’ Compensation: Signature: For purposes of the workers’ compensation system, this bill allows documents that require a signature to be filed with an “electronic signature.”

A.B. 2123 – Paid Family Leave (PFL): Effective January 1, 2025, an employer can no longer require an employee to use up to 2 weeks of accrued vacation time before receiving PFL benefits.

S.B. 399 – California Worker Freedom from Employer Intimidation Act: Employees cannot be subject to adverse employment actions for failure to attend certain employer-sponsored meetings relating to religious or political matters.

S.B. 1137 – Protected Characteristics: Amends the Fair Employment and Housing Act (FEHA) to preclude discrimination based on an “intersection” of two or more protected characteristics.

A.B. 2499 – Victims of Domestic Violence: This extensive bill makes many changes to existing law. Among other changes, it prohibits discrimination or retaliation against an employee who takes time off to serve as a juror or witness. Employers must provide a reasonable accommodation to an employee who is a victim or has a family member who is a victim of a qualifying act of violence. The bill contains new notice requirements.

S.B. 1340 – Enforcement of Workplace Discrimination Laws: Revises existing law to outline procedures to apply when local agencies enforce discrimination claims typically handled by the Civil Rights Department (CRD) (if the local jurisdiction has an anti-discrimination law).

S.B. 1100 – Driver’s Licenses: New 2-part test applies before an employer can ask for a driver’s license from a job applicant. Both conditions must be met: (a) The employer reasonably expects driving to be one of the job functions for the position; and (b) the employer reasonably believes that satisfying the job function

described in (a) using an alternative form of transportation (such as Uber or Lyft) would not be comparable in travel time or cost to the employer.

S.B. 988 - Freelance Workers: Must provide a written contract to freelance workers if they are providing services of \$250 or more. Once services commence, the hiring party cannot ask the worker to: (a) Accept less compensation than the amount of compensation specified in the contract, or (b) provide more goods or services or grant more intellectual property rights than agreed to in the contract.

A.B. 3234 – Voluntary Social Compliance Audits: If an employer conducts a “social compliance audit,” the employer shall post a clear and conspicuous link on its internet website to a report detailing the findings of the employer’s compliance with child labor laws.

Minimum Wage

The minimum wage in California is increasing to **\$16.50** per hour effective **January 1, 2025** (up from \$16.00/hour). This new minimum wage applies to all employers. (**Note:** Watch Proposition 32, which will impact the minimum wage if it passes.)

For 2025, the salary threshold for administrative, executive, and professional exemptions will be **\$68,640** per year (\$5,720 per month) (up from \$66,560/year or \$5,546.57/month). Also for 2025, the salary threshold for computer professionals will be **\$118,657.43** per year (\$9,888.13 per month or \$56.97 per hour) (up from \$115,763.35 annually).

As a result of legislation passed last year (S.B. 525), the minimum wage for certain health care workers increases effective **October 16, 2024** (S.B. 525); the hourly rate is between **\$18 and \$23** per hour, depending on type of facility where the individual works. Finally, a reminder that also as a result of legislation passed last year (A.B. 1228), the minimum wage for certain fast food restaurant employees was set at **\$20** per hour effective **April 1, 2024**.

Many municipalities in California already have higher minimum wages, and many adjust their minimums on **January 1st** (and other municipalities adjust their minimum wages on **July 1st**). Employers need to know which minimum wage limits apply to their workforce. Municipalities adjusting their minimum wage on **January 1, 2025**, may include Belmont, Burlingame, Cupertino, Daly City, East Palo Alto, El Cerrito, Foster City, Half Moon Bay, Hayward, Los Altos, Menlo Park, Mountain View, Novato, Oakland, Palo Alto, Petaluma, Redwood City, Richmond, San Carlos, San Diego, San Jose, San Mateo (city and county), Santa Clara, Santa Rosa, Sonoma, South San Francisco, and Sunnyvale.

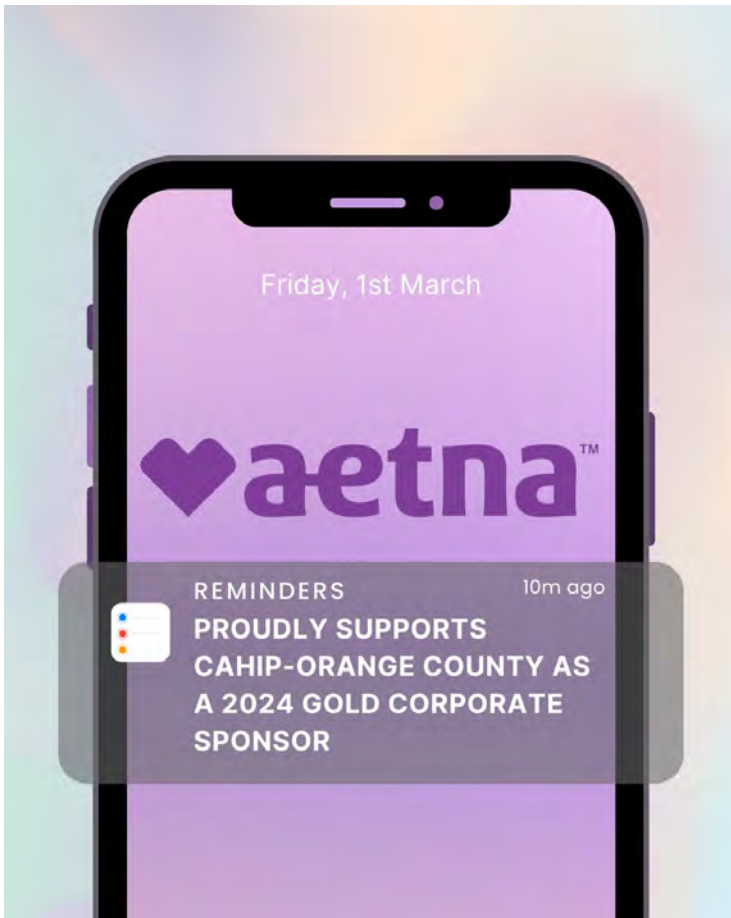
Employers impacted by these changes need to update payroll processing and workplace posters, and may need to use the new minimums to determine ACA section 4980H(b) affordability.

MUNICIPALITIES: HIGHLIGHTS

Fair Chance Ordinances (FCOs)

San Diego: Businesses in unincorporated areas of San Diego County

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[&] Effect

Elements [Passion. Authenticity. Collaboration. Trust.]

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Don't Forget Our Upcoming Programs!

November 15, 2024

Pizza Party

December 13, 2024

Harbor Cruise

January 14, 2025

Legal Update

February 11, 2025

Sales Symposium

Legal Briefs, Continued from page 10

and with 5 or more employees must comply with the new FCO as of October 10, 2024. The FCO prohibits employers from asking about or considering an applicant's criminal history before a conditional job offer is made. The FCO also requires a written individualized assessment to determine if an applicant's criminal history directly relates to the job duties, among other requirements.

Los Angeles: Businesses in unincorporated areas of Los Angeles County and with 5 or more employees must comply with the new FCO as of September 3, 2024. In general, the FCO prohibits employers from asking about or considering an applicant's criminal history before a conditional job offer is made, and requires employers to perform an individualized assessment regarding an applicant's conviction history before rescinding a job offer.

Action Items: These ordinances are detailed, and they overlap with related restrictions at the state level (the Ban-the-Box law) and in other municipalities (including the City of Los Angeles and San Francisco). Employers should consult their employment lawyer to ensure they are in full compliance with applicable ordinances—as well as all the new workplace laws signed by Governor Newsom and taking effect in the new year. #

Editor's Note: Marilyn can be reached at marilyn@monahanlawoffice.com. See her ad on page 6.

Mark Your Calendars for Our Upcoming CAHIP-OC Programs!

November 8, 2024

November Membership Pizza Party

November 15, 2024

Holiday Cruise Event

December 13, 2024

January Annual Legislative Update Meeting

January 14, 2025

Brea Community Center

CAHIIP-OC Sales Symposium

February 11, 2025

Lake Forest Community Center

HIPAA Updates, Continued from Page 8

Penalty resolves OCR's investigation concerning Providence Medical Institute's compliance with the HIPAA Security Rule.

OCR initiated an investigation following the receipt of a breach report filed by Providence Medical Institute in April 2018, which reported that its systems were impacted by a series of ransomware attacks that affected the electronic protected health information (ePHI) of 85,000 individuals between February and March 2018. OCR's investigation determined that servers containing ePHI were encrypted with ransomware three times. OCR found two potential violations of the HIPAA Security Rule, including failure to have a business associate agreement in place and failure to implement policies and procedures to allow only authorized persons or software programs access to ePHI.

In March 2024, OCR issued a Notice of Proposed Determination seeking to impose a civil money penalty. Providence Medical Institute waived its right to a hearing and did not contest OCR's findings. Accordingly, OCR imposed a civil money penalty of \$240,000.

The Notice of Proposed Determination may be found at: <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/pmi-npd/index.html>

OCR recommends that health care providers, health plans, clearinghouses, and business associates that are covered by HIPAA take the following steps to mitigate or prevent cyber-threats:

Review all vendor and contractor relationships to ensure business associate agreements are in place as appropriate and address breach/security incident obligations.

- Integrate risk analysis and risk management into business processes; conducted regularly and when new technologies and business operations are planned.
- Ensure audit controls are in place to record and examine information system activity.
- Implement regular review of information system activity.
- Utilize multi-factor authentication to ensure only authorized users are accessing ePHI.
- Encrypt ePHI to guard against unauthorized access to ePHI.
- Incorporate lessons learned from incidents into the overall security management process.
- Provide training specific to organization and job responsibilities and on regular basis; reinforce workforce members' critical role in protecting privacy and security.

On October 18, 2024, **OCR Released a Cybersecurity Video: Ransomware Update**, as part of Cybersecurity Awareness last month.

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out-of-network coverage for mental health or substance use disorder benefits if the plan provides coverage for medical or surgical benefits provided by out-of-network providers” (Congress.gov; HR 6983, 110th Congress).

The law was updated and expanded in 2008, and in 2021, a detailed comparative analysis relating to limits under the mental health parity law was announced.

In 2008, the federal Departments and federal government began with serious enforcement of mental health parity. It was at this time that some self-funded plan sponsors made the decision to not offer mental health benefits, so that they did not have to comply with the cumbersome and expensive mental health parity requirements. How could they do that? Because the MHPAEA does not require self-funded health plan sponsors to offer mental health benefits... but if you do, you must offer all of the parity stipulated in the 2008 law. We will come back to that later in this article. Final rules for the MHPAEA in 2008 were published in 2013.

The MHPAEA in 2013 also extended the parity requirements to substance abuse disorders.

The MHPAEA was amended by the Affordable Care Act (ACA) to also apply to individual health insurance plans. It’s important to note that MHPAEA does not apply directly to small group health plans, although it’s requirements are applied indirectly in connection with the ACA’s essential health benefits requirements. In general, it applies to group health plans of employers with more than 50 employees, non-federal government health plans with more than 50 employees, and individual plans.

In 2021, the Consolidated Appropriations Act (CAA) established a new federal mandate which required the Departments to investigate group health plans and health insurance issuers and their compliance with non-qualitative treatment limits (NQTLs). It also requires the Departments to publish the names of non-compliant plans in a report to Congress, and provide guidance on documentation requirements of the NQTL.

In 2023, proposed rules were issued on MHPAEA, and in September, 2024, the final rules were released, which had some substantial differences from the 2023 proposed rules.

Since 2021, plan sponsors and issuers were required to start planning for the 2025 and 2026 requirements. With the release of the final rules, we now have more detailed information on how to implement

the requirements beginning with plan renewal dates starting January, 2025.

MHPAEA & Terminology

This federal law generally prohibits group health plans and health insurance issuers that provide mental health or substance abuse disorder benefits from imposing any less favorable benefit limitations on those benefits than what is offered on the medical/surgical benefits. With each new law comes a series of acronyms and definitions that most health plan sponsors are not aware of, so I wanted to get those plan sponsors and the broker community up to speed

so that all of this may make more sense to them. These definitions and terminology were taken from government documents such as the Fact Sheet for MHPAEA (issued by the Departments).

Quantitative Treatment Limitations

These limitations are numerical in nature, such as the number of visitation limits, which may be included in a benefit plan.

Non-Qualitative Treatment Limitations (NQTLs)

These limitations are non-numerical limits on the scope or duration of benefits for treatment, such as pre-authorization requirements.

New Definitions in the Final Rule

Evidentiary Standards

These standards are any evidence, sources, or standards that a plan or issuer considered or relied upon in designing or applying a factor with respect to an NQTL.

Factors

Factors are all information, including processes and strategies (but not evidentiary standards), that a plan or issuer considered or relied upon to design an NQTL or to determine whether or how the NQTL applies to benefits under the plan or coverage.

Processes

Processes are actions, steps, or procedures that a plan or issuer uses to *apply* an NQTL.

Strategies

Strategies are practices, methods, or internal metrics that a plan or issuer considers, reviews, or uses to *design* an NQTL.

Meaningful Benefits

If a plan or coverage provides any benefits for a MH condition or SUD in any benefits classification, the final rules state that it must provide meaningful benefits for that condition or disorder in every classification in which meaningful M/S benefits are provided.



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Whether the benefits provided are meaningful is determined in comparison to the benefits provided for M/S conditions in the same classification. Meaningful benefits require coverage of a core treatment for that condition or disorder in each classification in which the plan or coverage provides benefits for a core treatment for one or more medical conditions or surgical procedures.

Material Differences and Reasonable Action

If the evaluated relevant data suggests that the NQTL contributes to material differences in access to MH/SUD benefits as compared to M/S benefits, that will be considered a strong indicator of a MHPAEA violation. Differences in access are material if, based on all relevant facts and circumstances, the difference in the data suggests that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to M/S benefits.

However, differences in access to MH/SUD benefits are not treated as material if they are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect, prevent, or prove fraud and abuse. If material differences in access exist, the plan or issuer must take reasonable action, as necessary, to address them to ensure compliance with MHPAEA in operation.

Plan Sponsor Choice – Mental Health Coverage or Not?

It's important to note that MHPAEA does not require self-insured plan sponsors to offer mental health benefits... but if you do, you must offer all of the parity stipulated in the 2008 law and all laws and regulations issued since. In a recently recorded podcast with guests Chris Condeluci, Esq, principal of CC Law & Policy (and attorney for the Self-Insurance Institute of America) and Jordan Smith, Chief Compliance Officer & Practice Leader on Mental Health Parity from Healthcare Reporting, we discussed the mental health parity and NTQL requirements. They have agreed to allow me to quote them from that podcast in this article (Benefits Executive Roundtable Podcast, Season 6, Episode 7, airing November 5, 2024). I asked Chris about the self-funded requirements related to MHPAEA. "Self-insured plan sponsors are not required to cover mental health disorder benefits... but most employers do, because employers offer health benefits to attract and retain talented workers, and the demand for good, comprehensive benefits includes mental health and substance abuse disorder benefits. Also, the past couple of years, with COVID, with social media, mental health and substance abuse and the opioid crisis, is that much more front and center, so more employers, now more than ever, are offering mental health and substance abuse disorder benefits in their suite of coverage."

If you do offer those benefits, you are subject to the mental health

parity law. What does that mean for employers? "Well, there are certain limitations that can be applied to any benefits covered under the plan, albeit mental health and substance disorder or medical/surgical benefits," Chris continued. In a nutshell, if you cover mental health benefits, they must be similar in nature to benefits offered under your medical/surgical plan. "There is a parity requirement. The limitations are essentially that we most know and talk about, is quantitative treatment limitations, or QTLs, which are limitations such as limits on the number of days or visits that are covered."

Chris went on to provide further explanation. "The other limit that is most notable, especially in the context of these final regulations... is non-quantitative treatment limitations (NQTLs). NQTLs are things like prior authorization, concurrent review, step therapy... essentially cost containment-type practices that are imposed

on mental health and substance abuse disorder benefits as well as med/surg. And the mental health law says there must be parity in those NTQLs applicable to each of those sets of benefits."

Why does this all seem so new, and why are plan sponsor employers now panicking about the compliance burdens in the last quarter of 2024? "It feels new," stated Jordan Smith. "This is not

a new requirement... it's really been around since the 1990s. Why does it feel so new? The CAA in 2021 brought this new requirement; the concept of parity has been around for a while. The concept of demonstrating that parity is also not really new, but it used to be a self-assessment... an *optional self-assessment*, but the CAA established a *mandatory self-assessment*, essentially conducting this comparative analysis. Fast forward to where we are today, we now have final rules on that. So, there have been guard rails and specific rules established on it. So, it feels new to the average self-insured plan sponsor, and really to anybody in the industry, because it was just something that the carriers were supposed to be doing... it existed in concept, but it didn't have teeth." Jordan continued: "I heard a former DOL investigator say that it really came about because people were really asleep at the wheel... They just weren't aware of what was happening, so while this parity thing existed long before the CAA, the CAA brought it into focus with this requirement, to be that wakeup call, to get people to acknowledge hey, this is not optional at this point."

We also discussed the mind-set of plan sponsors and those business associates that assist them related to MHPAEA. "The other piece of what feels new is the clarity around you, and you, plan sponsor, are in the driver's seat. The buck stops with you." What does that mean, specifically? Jordan continued, "You now have to demonstrate how you're doing this, and that is the wakeup call;



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that is the requirement of the self-insured plan sponsor."

As Jordan stated above, Chris felt also that "plan sponsors really weren't complying. Insurance carriers really weren't doing the right things when it comes to coverage, and the federal departments said that is really not cool with us, so we're going to put an additional layer, and additional requirement, which is why it seems new."

Audit/Enforcement

There seems to be more enforcement in mental health than other areas of compliance right now. Mental Health Parity is truly a hot topic with regulators and investigators in the federal departments now.

I asked Chris and Jordan about the current state of the market, and about current enforcement, which appears to be heavier in Mental Health related areas than other compliance areas in benefits.

"In 2008 and beyond," Chris explained, "the federal departments have been enforcing the Mental Health parity law in earnest, and have stepped up their audits and enforcement efforts significantly, and that has really lead to consternation in the employer and labor communities, when it comes to sponsoring self-funded plans, and consternation on the provider side of the ledger..."

How does this work in the real world and audits? Chris explained:

"I represent plan sponsors and some of my clients have been through a mental health parity audit... It comes out of the blue. It starts with a letter from the DOL, knocking on your door, saying 'show me, illustrate to me that you are complying with the mental health parity law,' which now includes this written comparative analysis... *A lot of the increased enforcement is due to the belief that no one was complying before.*" Chris continued, "Depending on the administration, one administration might feel that mental health benefits is more important than enforcing another benefit-related matter, and that is going to become a priority of that particular administration. In particular, the Biden administration, which led to final regs, a lot of that was driven by concern that there was limited access to mental health benefits. And a lot of that understanding or realization came through the audit activity. That was another driver behind the enforcement efforts and the audit activity.... To make sure that plan sponsors are not only complying, but that there is adequate access to the benefits."

Jordan discussed his thoughts on the audit and enforcement side. "Data matters," Jordan stated. "It is part of the transparency movement. In order to do this analysis properly, you have to be able to look at how are you reimbursing providers? Are you incentivizing them to be in your network? Does it make sense for the average mental health provider to participate when they know they are going to get the

crumbs compared to the big, more attractive practices of medicine? This movement of bringing things to light... The operational data, the metrics, the quality control, how do you know the design, the application some of these technical terms of the requirement, are actually working in parity? The DOL and CMS really wants to see the operational data. What was the impact, what were the outcomes?... That's all reflected in the final rule."

What areas of mental health parity seem to be the largest target item for audits? Jordan provided his thoughts. "Autism spectrum disorder," he stated matter-of-factly. "Limitations related to ASD is the second-most likely thing I've seen lead to one of these investigations on the enforcement side. The first is the existing investigation, that becomes a mental health parity investigation. The providers are highly informed. You can ask your plan to demonstrate this and if not, they push back and report it to EBSA... You want to pay close attention to that."



NTQL Analysis

There are certain types of limitations that aren't directly quantifiable, and these are called Non-Quantitative Treatment Limitations. Both quantitative limitations and non-quantitative limitations may be placed on mental health plans, whether fully insured or self-funded, and both are commonly used for cost containment. However, the qualitative limitations are easily quantifiable and have a numerical value,

such as the number of visit maximums, or the number of days they are authorized to spend in a treatment facility. The non-quantitative limitations are not as easy to quantify and have no actual numerical value. These include things like pre-authorization requirements on services, prescription drug formularies, tiered network designs, step therapy, and medical necessity appropriateness.

Comparative Analysis Content Requirements

Plan issuers (insurance companies) and self-funded plan sponsors are required to complete an NTQL analysis. This very detailed analysis requirement goes into effect for plan years on or after January 1, 2025. This is the most difficult part of the MHPAEA requirements.

In the podcast interview, Chris Condeluci stated this about the NTQL analysis... "Congress often times acts for a reason, and when it comes to this comparative analysis requirement...[it] actually is a requirement on the plan sponsor to explain, in what I will call is *excruciating detail*, how and why the plan sponsor is providing parity with mental health vs med/surg... So now you have this written requirement of detailing how and why you are compliant with the mental health parity law..."

There are six items of specific information that health plans should

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include within a given written NQTL analysis (Departments “Final Rules Under the Mental Health Parity and Addiction Equity Act (MHPAEA) Fact Sheet”):

- Description of specific coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits
- Identification and definition of factors and evidentiary standards used to design or apply the NQTL
- A description of how factors are used in the design or application of the NQTL
- A demonstration of comparability and stringency, as written
- A demonstration of comparability and stringency, in operation, including the required data, evaluation of that data, explanation of any material difference in access, and description of reasonable actions taken to address such differences; and
- Findings and conclusions



Effective Dates

According to the Departments “Final Rules Under the Mental Health Parity and Addiction Equity Act (MHPAEA) Fact Sheet,” the final rules generally apply to group health plans and group health insurance coverage on the first day of the first plan year beginning on or after January 1, 2025.

The meaningful benefits standard, prohibition on discriminatory factors and evidentiary standards, relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses apply on the first day of the first plan year beginning on or after January 1, 2026 (guidance is forthcoming).

The final rules apply to health insurance issuers offering individual health insurance coverage for policy years beginning on or after January 1, 2026.

Until the applicability date, plans and issuers are required to comply with the existing requirements, including the CAA, 2021 amendments to the MHPAEA.

There are also other timeframes to keep in mind. A Fiduciary Certification from the plan sponsor is required in 2025 (more information below).

Stop Loss Implications if Adverse Determination Given

Many self-funded plan sponsors have great concern about the stop loss implications in the event that the Departments review their plan

and there is an adverse determination given. Rightly so. If the plan sponsor receives an adverse determination, the stop loss carrier can (and likely will) decide not to cover the claim.

Lessons Learned From the Final Rules

I asked Jordan Smith during my podcast what he felt the lessons learned were from the release of the final rules.

“Things that we were interpreting from investigations, conversations with investigators, final decisions, determinations, the reports to Congress...” were things we learned from. “Some of the things like definitions.... A ‘strategy’ is something that you used on the front end, as

you’re designing an NQTL, whereas a ‘process’ is something that is used in the application of that NQTL and the daily life of the plan.... We now know what we expected before.”

Other things that were learned, according to Jordan, include: “There is a clear timeline for what enforcement looks like. That wasn’t as explicit prior to the final rule. You’ve got 10 days from the date the DOL requests your proof of parity... What happens after that? You’ve got a 45-day corrective action period if they issue an adverse initial determination. You’ve got 7

days after an adverse final determination to notification to plan members. So there has been clarity brought to the enforcement side of things that we didn’t have before.”

Good Faith Standard, Fiduciary Certification & Monitoring

Unfortunately, there is not a true good faith standard in the final rule. I asked Jordan about this. “We really would have liked something like the early ACA reporting days, where it said if you do this, that demonstrates good faith effort.... We really were looking for something to acknowledge that they don’t have the controls over all of the administration, design, application of these NQTLs or parity, always. What we got was a Fiduciary Certification. This is something that is effective 1-1-25, where plan sponsors don’t have to certify that the comparative is in compliance and is fully sufficient. They [do] have to certify that they engaged in a prudent process to identify a qualified service provider.... to prepare and conduct a comparative analysis. And then you have a duty to monitor that.” He continued, ““The plan sponsor can say ‘we’re awake at the wheel.’”

This process is similar to ERISA fiduciary monitoring of service providers.

Chris Condeluci had a lot to say about the fiduciary requirements, particularly on monitoring, in the podcast episode. “Fiduciary issues and fiduciary liability is front and center nowadays. We now have a regulation that talks about a fiduciary certification... The proposed rule required the plan sponsor to certify that it was compliant.... That was a very high bar... At least the Departments backed off on that slightly, where they didn’t require the plan sponsor to certify or attest

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In recognition of National Cybersecurity Awareness Month, OCR has produced a new video this October to provide awareness and education for organizations covered under the HIPAA Rules on ransomware and how compliance with the HIPAA Security Rule can help such organizations combat ransomware.

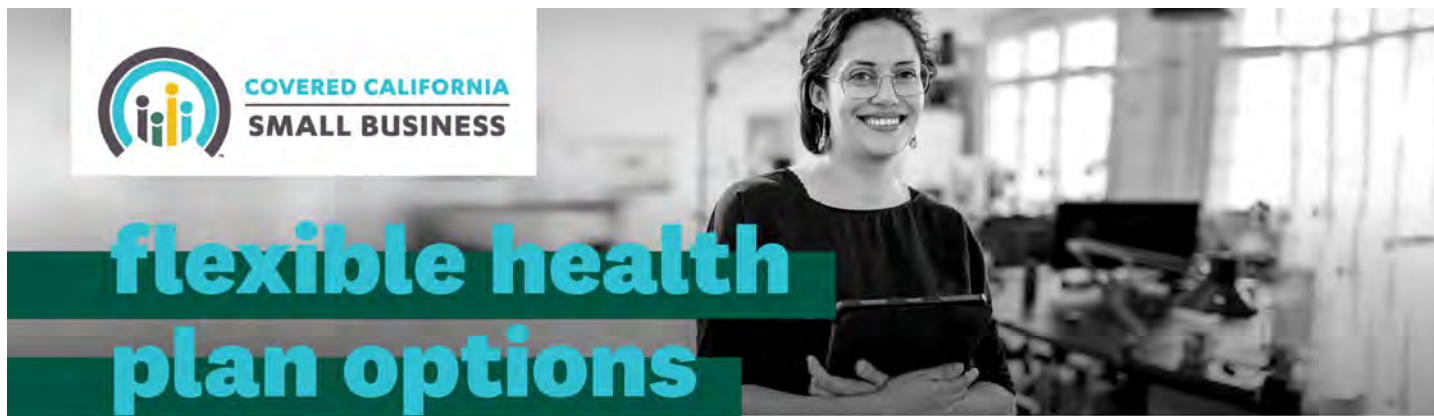
This video updates the health care industry on the ransomware trends OCR sees in its cybersecurity investigations, OCR guidance and resources, best practices and practical advice on how HIPAA compliance can help HIPAA regulated entities prevent, detect, respond to, and recover from ransomware attacks. Topics include:

- OCR breach and ransomware trend analysis

- Review of prior OCR ransomware guidance and materials
- Analysis of the ransomware attack chain
- Explore how Security Rule compliance can combat ransomware

The video presentation may be found on OCR's YouTube channel at: [USGovHHSOCR](https://www.usgovhhsocr.com)

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Insurance companies vary by region.

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that they are compliant. Instead, the federal Departments said you must adhere to your fiduciary duties, which one is the duty to monitor.”

Chris also referred to the regulations’ Preamble. “The Departments specifically said... we would expect a plan sponsor in satisfying their duty to monitor, in the context of the comparative analysis, to, at a minimum, review the analysis prepared by the service provider, ask questions and discuss the contents of the analysis with the service provider, to understand the findings, and the conclusions set forth in the analysis, and assure that the service provider gives you assurances that your analysis is compliant.”

Again, this process Chris is talking about is similar to ERISA fiduciary monitoring of service providers that I have discussed many times in articles, webinars, seminars and on podcasts.

EAPs – Are They Subject to MHPAEA?

One of the biggest questions I’ve had from my clients and industry friends and associates relates to EAP programs and whether they have to comply with the final rules for mental health parity requirements.

In my podcast episode, I asked Jordan Smith and Chris Condeluci about self-funded plans that have eliminated mental health and substance abuse disorder from their medical plans but have a limited scope benefit standard EAP plan that offers a few therapy sessions, as well as services like helping with college planning, finance items and other things employee plan participants may have a need for. Does that limited scope EAP plan draw that self-funded employer into compliance with the mental health parity act?

Jordan Smith stated “If all you’re offering is a traditional EAP, an EAP is an excepted benefit. If it’s not requiring participation in major medical plan, if it’s not providing those additional benefits beyond that preventative assistance program, it does not create an obligation for falling under and complying with MHPAEA. That’s addressed in the previous guidance and also briefly in the final rule... There are several stipulations.”

Chris Condeluci followed that with his advice as an attorney who deals often in this area. “You do need a legal analysis, because it’s easy to say, which I agree with Jordan, 100%, an EAP is an excepted benefit and therefore is not subject to the mental health parity law. But you have to analyze whether the facts and circumstances and the structure of your EAP indeed meets that excepted benefit definition, which then therefore can make you feel comfortable.. ‘Ok, I don’t gotta worry about it!’ But, to Jordan’s point, if your EAP is doing things that does not meet the requirements for satisfying the excepted benefit requirement, you may not be an excepted benefit... You’ve got to do the analysis.”

I know that other attorneys do feel that in many cases EAPs do have to comply with MHPAEA as they can be ERISA plans. So, understand that, as Chris said, a legal analysis needs to be completed to be sure your EAP or your clients’ EAPs meet the excepted benefit standard.

Conclusion

The most important thing to understand about Mental Health Parity and all related to it is that if you haven’t begun to examine your requirements (or your clients’ requirements), it’s time to dig and get things done that you’ve been putting off for a couple of years now. There is no more time to put this on the back burner. If you or your client have not yet begun the NQTL analysis, or simply have no idea how to do it, seek assistance from experts who do.

If this all seemed way too confusing, as I said in the beginning, it is. But for those of you that finished reading this article, I hope that I helped you avoid that aforementioned moment when your client asks you something about mental health parity and any of these new rules, and helped you to avoid that terrifying moment where your face may show just how little you know about something related to mental health parity. I hope that I have helped save you from that potential embarrassment. I guess that means I’ve done my job. ##

Author’s Note: I’d like to thank Chris Condeluci and Jordan Smith for the informative podcast they appeared on and all of the incredible information they shared, as well as their permission to quote them in this article. Chris can be reached at chris@cclawandpolicy.com, and Jordan can be reached at js@selfinsuredreporting.com.

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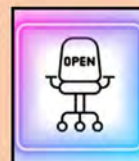
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Navigating the Ethical Landscape of Cybersecurity

By: Adriana Mendieta & Miguel (Mike) Villegas

In today's hyper-connected world, cybersecurity is a fundamental concern for individuals, organizations, and particularly for agents and brokers at the Orange County California Association of Health Insurance Professionals (CAHIP-OC). As digital threats grow more sophisticated, so must our ethical approaches to safeguarding sensitive client and business data. The presentation to CAHIP-OC members this past October explored key areas where ethical decision-making intersects with cybersecurity, providing a comprehensive framework for addressing both internal and external risks. If you missed this meeting, there is still time to get additional information.

One of the primary ethical responsibilities in cybersecurity is the protection of data privacy. Agents, brokers, and ethical professionals must prioritize robust security protocols, recognizing that protecting client and stakeholder data is not only a legal requirement but a moral imperative. Educating agents, brokers, and stakeholders about their role in cybersecurity fosters a culture of security, with everyone contributing to maintaining data integrity. Best practices, such as regularly updating systems and proactively managing cyber risks, ensure these ethical standards are consistently met.

Transparency is a cornerstone of ethical cybersecurity practices, particularly when reporting cyber incidents. For agents and brokers, it's critical to have systems in place for the immediate detection of threats. Once detected, incidents must be promptly reported to the relevant authorities, including clients and insurance carriers, where appropriate.

Ethical cybersecurity is proactive. This means constantly identifying and mitigating risks before they become problems. Agents and brokers must address internal vulnerabilities, such as outdated systems or inadequate access controls, while staying vigilant against external threats by using advanced threat intelligence systems. Proactive steps, such as conducting tabletop exercises, encrypting sensitive data, and enhancing incident response plans, are vital to staying ahead of evolving cyber threats.

Within the realm of corporate governance, directors and officers (D&Os) bear significant ethical responsibilities to understand and mitigate the cyber risks facing their organizations. For agencies and brokerages, this means setting robust cybersecurity policies, ensuring adequate resources are allocated for security initiatives, and maintaining oversight. D&Os have a duty to ensure their organizations are prepared for potential cyber incidents, making cybersecurity not just a priority but an organizational obligation.

A strong, ethical incident response begins with preparation. Agents and brokers must have clear response plans and dedicated teams in place. When an incident occurs, swift identification and containment of the breach are crucial. The focus then shifts to eradicating the root cause of the threat and restoring systems to normal. Recovery efforts must

remain transparent and accountable throughout the process. The lessons learned from each incident, along with practice from tabletop drills, serve to continuously improve the organization's cybersecurity posture.

The dark side of cybersecurity includes unethical practices such as neglecting regular security updates or failing to report incidents. For agents and brokers, such actions not only jeopardize client data but also erode trust, potentially leading to financial losses and legal repercussions. By contrast, ethical alternatives, such as maintaining transparent reporting protocols and regularly updating systems, help organizations maintain high standards of conduct while reducing the risk of cyber threats.

Embedding ethical cybersecurity into an organization's culture is essential, whether the business is a small two-person agency or a large enterprise. Continuous education on the latest cybersecurity best practices, fostering open communication about security concerns, and ensuring leadership actively participates in security initiatives are crucial steps. Encouraging collaboration between IT and other departments will help integrate cybersecurity into all aspects of the business, ensuring that it becomes an ongoing priority.

In conclusion, the ethical landscape of cybersecurity is complex but critical for agents, brokers, and organizations alike. By prioritizing data protection, transparency, and continuous improvement, CAHIP-OC attendees receive an ethics CE while learning how to successfully navigate this landscape, maintaining trust and safeguarding the digital world. ##

Editor's Note: Adriana can be reached at adriana@mendieta.net

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NABIP PAC has a new name but it remains committed to moving forward and fulfilling its mission to support candidates that support our industry. I'm writing today to explain what NABIP's political action committee is and how it operates.

What is the National Association of Benefits and Insurance Professionals Political Action Committee (NABIP PAC)?

- NABIP PAC is a separate segregated fund (SSF) that allows for political advocacy from the connected organization -- in this case, NABIP.
- For this reason, the PAC (candidate fund) is restricted to raising money from dues-paying members.
- PAC money is NOT tax-deductible. Contributions are not deductible for state or federal tax purposes.
- NABIP PAC has two different accounts:
 - o Candidate Account
 - o Administrative Fund

What is the Candidate Account?

- It is made up of individuals' contributions through personal credit cards or bank accounts.
- Funds from this account are given to political candidates, both challengers and incumbents, Democrats and Republicans.
- NABIP members, their spouses and NABIP staff can give up to \$5,000 each year (federal law).

What is the Administrative Fund?

- Businesses can contribute to the Admin Fund.
- State and local chapters can also contribute.
- Money in this account goes to the operating costs of NABIP PAC so that the Candidate Account can be reserved solely for political contributions.
- Unlike the Candidate Account, there are no contribution limits on the Administrative Fund.

How does the NABIP PAC money we donate get spent by candidates?

- Winning Senate candidates spent an average of \$16

million in 2022.

- On average, \$2.0 million was spent to win a House seat in 2022.
- A NABIP PAC donation of \$2000 is just one in 2000 groups of people contributing to total amount needed to win that House seat.
- Needless to say, members of Congress have many groups like NABIP that expect their legislative agendas to become a priority through their donation.
- **Through NABIP PAC, NABIP gets time and access to members of Congress to advocate on behalf of agents and brokers.**

What are the rules for communication of available money for Candidate Account Fund?

- A member of Congress and his or her staff are never allowed to discuss the campaign or fundraising while using government resources. This includes in their office, while they are working on a Congressional activity, or using an email or phone number provided by the member's office.

Reach out to me Cathy@BAISins.com or Gail to view/ or update your NABIP-pac fund giving level here and donate today if you are not currently!

Cathy Daugherty, VP of PAC

**Are you Ready to Contribute
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**If so, please complete the form
on page 27!**

**Note: CAHIP PAC contribution form can be
found on page 18!**



The purpose of the NABIP PAC is to raise funds from NABIP members to support the political campaigns of candidates who believe in private-sector solutions for the health and financial security of all Americans.

Contribute securely at www.nabippac.org

Step 1: Tell us about yourself. *(All information must be completed in full by contributor.)*

Name: Occupation:
Employer: Address:
Email: Phone:

Step 2: Please select (A) Fund (B) Frequency (C) Contribution Level

☐ New Contributor ☐ Past Contributor ☐ Change Contribution to Amount Checked Below

A. Choose a Fund

☐ Candidate Fund* ☐ Administrative Fund**

**Candidate Fund can ONLY accept personal contributions.*

***Administrative Fund can accept corporate contributions.*

B. Contribution Frequency

☐ One-Time Contribution

☐ Charge my account annually for this amount.

☐ Monthly Contribution (Recurring)

Credit card or bank account will be charged monthly.

C. Contribution Levels

		(Annual)	(Monthly)
Member	☐	\$150	☐ \$12
Bronze	☐	\$365	☐ \$30
Silver	☐	\$500	☐ \$42
Gold	☐	\$750	☐ \$63
Platinum	☐	\$1,000	☐ \$85
Diamond	☐	\$2,000	☐ \$170
Double Diamond	☐	\$3,000	☐ \$250
Triple Diamond	☐	\$5,000	☐ \$415
Amount not listed	☐	\$	☐ \$

Did a NABIP member refer you? If so, who?

Step 3: Provide your method of payment.

(Payment must be from a personal credit card or bank account if contributing to the Candidate Fund.)

Credit or Debit Card ☐ American Express ☐ Discover ☐ Mastercard ☐ Visa

Card Number: Expiration Date: (mm/yy):

CVV: Zip Code:

Checking Account

Bank Routing Number: Account Number:

Signature

☐ I authorize NABIP PAC to initiate charges to my personal bank account or credit card as shown above.

Signature: Date:

Step 4: Submit this form. Mail

NABIP PAC
999 E Street NW, Suite 400
Washington, DC 20004

Fax

202-747-6820

Email

nabippac@nabip.org

A contribution to a Political Action Committee is not tax deductible. Only NABIP members, their immediate families and NABIP staff may contribute. Only U.S. citizens and permanent residents may contribute. Any guidelines mentioned for contributions are merely suggestions. You may contribute more or less than the guidelines suggest, and the National Association of Benefits and Insurance Professionals (NABIP) will not favor nor disadvantage you by reason of the amount of your contribution or your decision not to contribute. Federal law requires PACs to report the name, mailing address, occupation and employer for individuals whose donations exceed \$200 in a calendar year. Federal law prohibits corporate or business donations to a federal PAC. Please make certain that your check or credit card is your personal account.

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Employer-Sponsored Coverage in California For Applicable Large and Small Employers and the Availability of Covered California Premium Tax Credits

By: Anne Kelly, CAHIP-OC Sponsorship Chair & Professional Development Committee Member

Health insurance coverage is a critical benefit for employees in California, providing essential financial protection for medical expenses and access to necessary healthcare services. Employer-sponsored health coverage is a popular option, but for those who do not receive such benefits or cannot afford the employer-provided plan, Covered California and its Premium Tax Credit (PTC) can be a viable alternative.

Understanding Employer-Sponsored Coverage in California

In California, employer-sponsored health coverage is one of the most common ways individuals obtain insurance. Employers typically offer group health insurance plans to their employees and, in many cases, subsidize a portion of the premium costs. These plans are often comprehensive, covering medical services such as doctor visits, hospital stays, prescription drugs, and preventative care.

Key Features of Employer-Sponsored Coverage:

- 1) **Employer Contribution:** Employers often pay a portion of the monthly premiums, reducing the amount employees must pay. Employers must offer coverage to full-time employees under the Affordable Care Act (ACA) if they have 50 or more full-time equivalent employees.
- 2) **Pre-Tax Premiums:** In many cases, employees pay their portion of the premium with pre-tax dollars, reducing their taxable income and lowering their overall tax liability. **This tax savings can amount to approximately 30% for employees, depending on individual tax brackets.**
- 3) **Comprehensive Coverage:** Employer-sponsored health plans are required to meet ACA standards, offering minimum essential coverage, which includes services like preventive care, maternity care, and mental health services.
- 4) **Employers Reduce FICA Matching TAX 7.65%** on Employees Pre-Tax Contributions towards benefits
- 5) **Workers' Compensation Savings:** Employers in California may also benefit from offering health insurance, as it **could reduce workers' compensation costs by an estimated 10% of employees' pre-tax premiums.** This is due to healthier employees being less likely to need workers' compensation claims.

While employer-sponsored coverage is beneficial, not all Californians can access or afford it, which brings us to Covered California.

Covered California and the Premium Tax Credit (PTC)

Covered California is the state's health insurance marketplace, where individuals and families can shop for and purchase health plans if they do not receive adequate employer-sponsored coverage. One of the primary benefits of purchasing coverage through Covered California is the availability of the Premium Tax Credit (PTC), which helps lower the monthly premiums for eligible individuals and families.

How the Premium Tax Credit Works:

1) Income-Based Eligibility: The Premium Tax Credit is available to individuals and families who earn between 100% and 400% of the Federal Poverty Level (FPL). In 2024, this translates to approximately \$14,580 to \$58,320 for an individual and \$30,000 to \$120,000 for a family of four. The credit is designed to cap the amount you spend on premiums as a percentage of your income.

Percentage of income paid for premiums based on household FPL <i>Based on second-lowest-cost Silver plan</i>	
Household FPL Percentage	Percent of Income
0-150% FPL	0% household income
150-200% FPL	0-2% household income
200-250% FPL	2-4% household income
250-300% FPL	4-6% household income
300-400% FPL	6-8.5% household income
400+% FPL	8.5% household income

REMINDER – Majority of Employees Pre-Tax their share of Employer Based Premiums – and Save 30% of their Contribution on payroll Taxes .

2) Sliding Scale Credit: The amount of the Premium Tax Credit is based on income and the cost of the second-lowest-cost Silver plan in the Covered California marketplace. Those with lower incomes receive a higher credit to offset the cost of premiums, while those with higher incomes receive a smaller credit.

3) Advance Payment Option: Eligible individuals can choose to receive the credit in advance, which lowers the amount they pay in monthly premiums. Alternatively, they can claim the credit when they file their tax returns.

The Interaction Between Employer-Sponsored Coverage and Covered California

While Covered California provides an essential option for those without employer-sponsored coverage, it is important to note that most employees who have access to an affordable employer-sponsored plan are not eligible for the Premium Tax Credit.

Employer Based Plans : Affordability Test: If an individual has access to employer-sponsored coverage, they generally will not qualify for the Premium Tax Credit unless the employer's plan is deemed "unaffordable." A plan is considered unaffordable if the employee's contribution exceeds 8.39% % of household income in 2024 and 9.02% 2025.

- **Measure Formula:** (Can also be Single Federal Poverty Level)
- **HRLY- Hrly rate@130Hrs @ 8.39% 2024 % or 9.02% 2025**
Note On an audit- HHS will use the employees Hrly rate January of the Tax yr in question or if hired Mid Year they will use earliest rate of pay.*
- **Salaried :** W2 Box 1 @ 8.39% 2024 % or 9.02% 2025

Scenarios When an Employee May Turn to Covered California:

- 1) **Unaffordable Employer Plan:** If an employee's share of the premium based on the lowest cost Min Value plan offered for self-only coverage exceeds 8.39% (2024) or 9.02% (2025) of their household income, they may opt out of the employer plan and be eligible for the Premium Tax Credit through Covered California.
- 2) **Inadequate Employer Coverage:** If the employer-sponsored plan does not meet the ACA's minimum standards for coverage, the employee may qualify for the Premium Tax Credit.
- 3) **Part-Time or Seasonal Workers:** Employees who do not work full-time or who are seasonal workers may not be offered coverage through their employer, making them eligible for plans and Premium Tax Credits on Covered California.

Conclusion

Employer-sponsored health coverage remains a dominant source of health insurance for many Californians, offering comprehensive benefits and **pre-tax savings**. However, for those who do not receive adequate coverage through their employer or find the employer's plan unaffordable, Covered California and the Premium Tax Credit provide a critical safety net. By offering financial assistance based on income, Covered California ensures that health insurance is within reach for individuals and families across the state. Employers and employees alike should understand the options available to make informed decisions about their healthcare coverage.

When a **small employer** offers affordable health coverage to employees, the Affordable Care Act (ACA) has clear guidelines on how employees' eligibility for subsidies through the Health Insurance Marketplace, like Covered California, is handled. *If an employee incorrectly receives Premium Tax Credits (subsidies) despite having access to affordable employer-sponsored coverage, this can lead to significant consequences both for the employee and for the government agencies involved, including the Department of Health and Human Services (HHS) and the California Franchise Tax Board (FTB).*

Affordability and Employee Eligibility for Premium Tax Credits

As discussed, an employee is ineligible for Premium Tax Credits through Covered California if they are offered affordable, minimum-value health coverage by their employer. If the employee's contribution for self-only coverage does not exceed 8.39% % of their household income (for 2024), and 9.02% (for 2025) the plan is considered "affordable," and the employee must accept the employer's coverage or forego financial assistance through the marketplace.

However, some employees might still choose to enroll in a marketplace plan and receive Premium Tax Credits, either due to misunderstanding eligibility rules or because they fail to disclose the availability of employer-sponsored coverage.

How HHS Handles Incorrect Marketplace Subsidies

The Department of Health and Human Services (HHS) oversees the operation of health insurance marketplaces and the issuance of Premium Tax Credits. If an employee who has access to affordable employer-sponsored coverage enrolls in a Covered California plan and receives Premium Tax Credits, HHS can:

- 1) **Verify Employer Coverage Information:** During the application process for Premium Tax Credits, the marketplace asks applicants about the availability of employer-sponsored health insurance. This includes whether the employee is offered affordable and adequate coverage by their employer. Employers may also be asked to submit information to confirm coverage details.
- 2) **Reconciliation at Tax Time:** When the employee files their federal tax return, they must reconcile the amount of Premium Tax Credits they received with their actual eligibility. If the employee received credits incorrectly because they had access to affordable employer-sponsored insurance, they may be required to repay part or all of the tax credits they received. This is done through the IRS based on information provided in tax filings (such as the employer's coverage information on Form 1095-C).

How the Franchise Tax Board (FTB) in California Handles Incorrect Subsidies

The California Franchise Tax Board (FTB) is responsible for state-level tax administration, and since Covered California operates under the ACA framework, the FTB works in conjunction with the IRS to enforce tax credit eligibility rules for Californians. If an employee incor-



CAHIP-OC Sales Symposium February 11th 2025 at Lake Forest Community Center Promises to be a Must-Attend Event: Highlighting Four Keynote Speakers

By: Gabriella Bellizzi - CAHIP-OC Vice President, Professional Development

This year's symposium features a stellar lineup of keynote speakers who bring a wealth of expertise in health, motivation, and insurance. Here's a closer look at the four dynamic speakers who will be leading the discussions:

1. Dr. Robert Lustig - Expert in Nutrition and Metabolic Health

Dr. Robert Lustig, a leading authority on nutrition, metabolism, and public health, is a global keynote speaker whose message will resonate deeply with those in the health insurance field. Known for his groundbreaking work on the dangers of sugar and ultra-processed foods, Dr. Lustig has authored several books, including *"Fat Chance"* and *"Metabocal."* Dr. Lustig's organization is also suing the Ultra Processed food companies.

His keynote, **"Mental Health is Metabolic Health of the Brain,"** will explore how diet and lifestyle effect metabolic brain health and related healthcare costs and what insurance professionals can do to address these challenges. Attendees will learn how the health insurance industry can better serve clients by promoting preventive care and healthier lifestyles. Dr. Lustig will be doing a Book signing at the event.

2. Dr. Sean Hashmi - Kaiser Permanente's Leader in Preventive Medicine

Dr. Sean Hashmi, Kaiser Permanente -Regional Medical Director Lifestyle and Obesity Medicine Kaiser Permanente, is widely recognized for his work in preventive medicine. Dr. Hashmi's keynote, will again be addressing Obesity & Metabolic Syndrome and the resulting Chronic Illnesses that are responsible for over 73% of Healthcare Spending. With a strong background in lifestyle medicine, Dr. Hashmi will share insights into how preventive care strategies can lower healthcare costs, improve patient outcomes, and offer new opportunities for insurance agents to engage with their clients in meaningful ways.

3. Devon Hughes - Motivational Speaker and Leadership Coach

Devon Hughes, a celebrated motivational speaker and leadership coach, brings a high-energy approach to helping individuals and organizations unlock their potential. With a background in coaching executives and teams across various industries, Hughes is known for his inspiring messages on resilience, mindset, and performance. His keynote will kick off the day with inspiration and gratitude and a lot of energy.

4. Phil Calhoun - Publisher of California Broker Magazine

We have invited Phil Calhoun, publisher of California Broker Magazine and a respected leader in the insurance industry, to speak to members and bring his expertise in brokerage, publishing, and industry trends to the stage. His keynote, "Navigating the Future of Insurance: Insights

from the Field," will offer an insider's perspective on the state of the California health insurance market, key trends shaping the industry, and how brokers can stay ahead. With decades of experience and a pulse on the latest market developments, Calhoun's presentation will provide actionable advice for brokers looking to enhance their business strategies and client relationships.

With such an impressive lineup of speakers and authors, the CAHIP Sales Symposium 2025 is set to provide invaluable insights into health, motivation, and industry trends. FREE autographed BOOKS which will be sponsored for the event will allow members to take away valuable lessons from today's speakers, each of these books sells for over \$20.

Whether it's learning about the role of nutrition in Mental Health from Dr. Robert Lustig, exploring preventive care and nutrition with Dr. Sean Hashmi, gaining motivation from Devon Hughes, or understanding the latest market trends from Phil Calhoun, attendees are sure to leave inspired and informed. Mark your calendars for February 11th—this event is not to be missed! ##

The CAHIP OC Professional Development Team wish to thank our members for attending our meetings and CE's this year. Under Gabriella Bellizzi's Word and Browns leadership we have won the NABIP Professional Development Award again. Our Team continues to strive to host renowned speakers and current subjects for our members.



Employer Sponsored Coverage & Premium Tax Credits, Continued from Page 31

rectly receives Premium Tax Credits, the FTB can take the following actions:

- 1) **State Tax Filing and Reconciliation:** Similar to the IRS process, California residents must **reconcile any Premium Tax Credits they received on their state tax returns**. If the FTB determines that an employee received credits improperly due to the availability of affordable employer-sponsored coverage, they may owe additional taxes to both the IRS and the state.
- 2) **Potential Penalties:** If the improper receipt of Premium Tax Credits is found to be deliberate or due to failure to provide accurate information, the FTB could impose additional penalties beyond the repayment of the credits.

Employer's Role in Preventing Incorrect Subsidy Use

Employers offering affordable coverage also play a role in ensuring that their employees do not improperly receive marketplace subsidies. Employers should provide clear communication regarding the affordability and value of their health plans, as well as supply employees with the required forms (like the Form 1095-C) that confirm the offer of health coverage.

Employers are not penalized if an employee chooses to go to the marketplace instead of enrolling in the employer plan, as long as the employer meets the affordability and minimum coverage requirements.

Consequences for Employees Receiving Incorrect Subsidies

If employees receive Premium Tax Credits despite having affordable employer-sponsored coverage, the main consequence is financial. Employees who are found to have improperly received tax credits will likely have to repay some or all of those credits when they file their taxes, which could lead to a significant tax bill.

Key Consequences for Employees:

- 1) **Repayment of Subsidies:** Employees will need to repay Premium Tax Credits if it's determined that they were ineligible due to access to affordable employer-sponsored coverage.
- 2) **Potential Penalties:** In addition to repayment, employees may face penalties if the improper subsidy use was due to negligence or intentional misrepresentation.
- 3) **Loss of Coverage:** In cases where the employee fails to correct the error, they could lose their marketplace coverage.

Summary

For small employers offering affordable coverage, employees generally cannot receive Premium Tax Credits through Covered California. If they do receive these credits incorrectly, the HHS and California Franchise Tax Board (FTB) will address the issue during tax reconciliation. Em-

ployees may be required to repay the subsidies and could face penalties. Proper communication between employers and employees, along with accurate reporting of available coverage, is essential to ensure compliance and prevent any financial consequences for the employee.

Requirement for Small Employers to Distribute the Marketplace Model Notice

Even though small employers (those with fewer than 50 full-time employees) are not required by the Affordable Care Act (ACA) to provide health insurance, they *are required to distribute the Marketplace Model Notice* to their employees, regardless of whether they offer health insurance or not.

This notice informs employees about the Health Insurance Marketplace, including Covered California, and explains how they can seek coverage if they do not have employer-sponsored health insurance or if the employer's plan is unaffordable or does not provide minimum value. Importantly, this notice is required whether or not the employer offers affordable coverage.

Key Points About the Marketplace Model Notice:

1) Who Must Provide the Notice? All employers subject to the Fair Labor Standards Act (FLSA), including those with fewer than 50 employees, must distribute the Marketplace Model Notice to their employees. This requirement applies to:

- Employers that do not offer any health coverage.
- Employers that offer health coverage, including affordable and minimum-value plans.

2) Purpose of the Notice: The Marketplace Model Notice is designed to inform employees about their options for obtaining health coverage through the Health Insurance Marketplace, such as Covered California. It explains:

- The availability of marketplace coverage.
- How to evaluate whether the employer's coverage is affordable and provides minimum value.
- The possibility of being eligible for Premium Tax Credits if the employer's plan is deemed unaffordable or does not meet minimum standards.

3) When to Provide the Notice:

- New employees must receive the notice within 14 days of their start date.
- Existing employees should have received the notice when the rule was first implemented in 2013, but providing updates or re-issuing the notice annually is a best practice, especially when there are significant changes in health coverage options

4) Content of the Notice: The notice includes two parts:

Continued on page 35

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NABIP Operation Shout! One of the primary ways we engage in advocacy for the consumer is by supporting legislation that ensures the future and stability of the insurance industry. Through [Operation Shout](#), you as a member have the opportunity to participate in this process. As legislative needs arise, you will be prompted by staff to participate in Operation Shout. Participating is quick and easy. 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](#)!

Don't Forget CAHIP-OC's Upcoming Events!

November 15, 2024

November Membership Evening Event—Pizza Party

December 13, 2024

Holiday Lights Cruise Event

Mark Your Calendars Now!

Employer Sponsored Coverage & PTCs, Continued from page 33

- **General Information:** This section explains the employee's ability to purchase insurance through the marketplace and provides an overview of employer-provided coverage.
- **Employer-Specific Information:** This includes details about the employer's health plan, whether it meets affordability and minimum value standards, and whether employees may qualify for Premium Tax Credits if the employer plan is not affordable.

5) Template Provided by the Department of Labor (DOL): The Department of Labor (DOL) has made available a **Model Notice** that employers can use to meet this requirement. The Model Notice comes in two versions:

- For employers who offer a health plan to some or all employees.
- For employers who do not offer a health plan.

How This Impacts Small Employers Offering Affordable Plans

For small employers who offer affordable and minimum-value health plans to their employees, the Marketplace Model Notice still needs to be distributed. However, this notice will help employees understand that because the coverage is affordable, they will generally not be eligible for Premium Tax Credits if they opt for marketplace coverage instead of the employer plan.

Example Scenario:

A small business with 40 employees offers an affordable health plan that meets ACA standards. Under the ACA's requirements, this employer must still provide the Marketplace Model Notice to all employees. The notice will explain that marketplace coverage is available, but it will also clarify that employees who have access to affordable, employer-sponsored coverage will likely be **ineligible for Premium Tax Credits** if they choose to purchase a plan through Covered California.

Summary of Marketplace Model Notice for Small Employers

In conclusion, even if a small employer offers affordable health coverage, they are still required to distribute the Marketplace Model Notice to all employees. This notice provides critical information about options through Covered California and the Health Insurance Marketplace, ensuring employees are aware of their choices and understand how employer-sponsored coverage affects their eligibility for Premium Tax Credits. Failure to provide this notice could result in compliance issues with the Department of Labor (DOL).

It's Open Enrollment Season

Make sure you are doing your due diligence at Open Enrollment, If the Employer Plans meet Min Value and are Affordable make sure you are disclosing this to the employees and they fully understand that precludes them for qualifying for Covered California tax Credits for themselves, however their dependents still may Qualify.

Make sure you are explaining that the Majority of employees will save 30% of their share of premiums on Reduced Payroll Taxes and compare that to the Covered California Tax Credits chart shown as the % of income they will pay towards the second lowest silver plan.

If you are doing this correctly- You will Distribute Model marketplace Notices. ##

References and Links

[2024 Federal Poverty Guidelines \(For 2025 Coverage\)](#)
([obamacarefacts.com](#))

[Health Insurance Marketplace Coverage Options and Your Health Coverage \(dol.gov\)](#)

[KEY-FACTS-ESI-and-PTC-Eligibility-8.20.pdf](#)
([healthreformbeyondthebasics.org](#))

[Affordable Care Act tax provisions questions and answers | Internal Revenue Service \(irs.gov\)](#)

[Covered California - Health for California Insurance Center](#)

Editor's Note: Anne is currently the VP of Sponsorships for CA-HIP=OC and a committee member of the Professional Development Committee. She can be reached at:

Program Eligibility by Federal Poverty Level for 2024

Your financial help and whether you qualify for various Covered California or Medi-Cal programs depends on your income, based on the Federal Poverty Level (FPL).

Federal Premium Tax Credit*											
SEE NOTE BELOW FOR INCOMES IN THIS RANGE											
Annual household income (federal tax year) / Alaska Native (AAN) Zero Cost Sharing											
AAN Limited Cost Sharing											
% FPL	0%	100%	138%	150%	200%	210%	250%	300%	322%	400%*	
1	\$0	\$11,880	\$20,781	\$27,870	\$39,600	\$42,078	\$56,450	\$68,050	\$83,740	\$103,700	\$118,800
2	\$0	\$19,750	\$36,308	\$49,800	\$72,600	\$76,452	\$100,750	\$120,075	\$147,480	\$184,650	\$219,000
3	\$0	\$24,680	\$45,392	\$62,250	\$90,750	\$95,567	\$125,375	\$150,112	\$187,840	\$234,600	\$279,600
4	\$0	\$30,000	\$54,000	\$75,000	\$112,500	\$118,125	\$154,375	\$185,250	\$228,375	\$285,000	\$341,250
5	\$0	\$35,140	\$64,811	\$89,700	\$134,550	\$141,188	\$181,594	\$217,912	\$267,440	\$334,300	\$391,150
6	\$0	\$40,280	\$75,966	\$105,900	\$158,850	\$166,219	\$215,062	\$258,075	\$317,600	\$397,000	\$476,400
7	\$0	\$45,420	\$86,130	\$121,650	\$182,475	\$190,250	\$245,312	\$293,875	\$362,400	\$453,000	\$543,600
8	\$0	\$50,560	\$96,271	\$136,800	\$205,200	\$213,375	\$275,000	\$327,500	\$407,000	\$508,500	\$609,000
9	\$0	\$55,700	\$106,411	\$151,500	\$225,000	\$233,625	\$301,250	\$358,750	\$448,250	\$560,750	\$673,250
10	\$0	\$60,840	\$116,552	\$166,650	\$247,500	\$256,125	\$329,375	\$391,875	\$491,875	\$614,875	\$737,875
11	\$0	\$65,980	\$126,693	\$181,800	\$270,000	\$279,000	\$357,500	\$425,000	\$537,500	\$670,000	\$802,500
12	\$0	\$71,120	\$136,834	\$196,950	\$292,500	\$301,875	\$385,625	\$458,125	\$580,625	\$723,125	\$865,625
13	\$0	\$76,260	\$146,975	\$212,100	\$315,000	\$324,375	\$413,125	\$490,625	\$613,125	\$765,625	\$918,125
14	\$0	\$81,400	\$157,116	\$227,250	\$337,500	\$346,875	\$440,625	\$523,125	\$650,625	\$813,125	\$975,625
15	\$0	\$86,540	\$167,257	\$242,400	\$360,000	\$369,375	\$467,500	\$555,000	\$692,500	\$865,000	\$1,027,500
16	\$0	\$91,680	\$177,398	\$257,550	\$382,500	\$391,625	\$495,625	\$588,125	\$735,625	\$918,125	\$1,080,625
17	\$0	\$96,820	\$187,539	\$272,700	\$405,000	\$414,375	\$523,125	\$620,625	\$778,125	\$970,625	\$1,153,125
18	\$0	\$101,960	\$197,680	\$287,850	\$427,500	\$436,875	\$549,375	\$651,875	\$819,375	\$1,023,125	\$1,225,625
19	\$0	\$107,100	\$207,821	\$303,000	\$450,000	\$459,375	\$581,875	\$689,375	\$866,875	\$1,080,625	\$1,298,125
20	\$0	\$112,240	\$217,962	\$318,150	\$472,500	\$481,625	\$607,500	\$720,000	\$907,500	\$1,123,125	\$1,350,625
21	\$0	\$117,380	\$228,103	\$333,300	\$495,000	\$504,375	\$635,625	\$752,500	\$949,375	\$1,184,375	\$1,403,125
22	\$0	\$122,520	\$238,244	\$348,450	\$517,500	\$526,875	\$663,750	\$785,000	\$991,875	\$1,245,625	\$1,455,625
23	\$0	\$127,660	\$248,385	\$363,600	\$540,000	\$549,375	\$691,875	\$817,500	\$1,034,375	\$1,306,875	\$1,508,125
24	\$0	\$132,800	\$258,526	\$378,750	\$562,500	\$571,625	\$719,375	\$845,000	\$1,077,500	\$1,368,125	\$1,560,625
25	\$0	\$137,940	\$268,667	\$393,900	\$585,000	\$594,375	\$747,500	\$877,500	\$1,120,625	\$1,429,375	\$1,613,125
26	\$0	\$143,080	\$278,808	\$409,050	\$607,500	\$616,875	\$775,625	\$907,500	\$1,163,750	\$1,490,625	\$1,665,625
27	\$0	\$148,220	\$288,949	\$424,200	\$630,000	\$639,375	\$803,750	\$939,375	\$1,206,875	\$1,551,875	\$1,718,125
28	\$0	\$153,360	\$299,090	\$439,350	\$652,500	\$661,625	\$831,875	\$971,875	\$1,249,375	\$1,613,125	\$1,770,625
29	\$0	\$158,500	\$309,231	\$454,500	\$675,000	\$684,375	\$859,375	\$1,004,375	\$1,292,500	\$1,674,375	\$1,823,125
30	\$0	\$163,640	\$319,372	\$469,650	\$697,500	\$706,625	\$887,500	\$1,036,875	\$1,335,625	\$1,735,625	\$1,875,625
31	\$0	\$168,780	\$329,513	\$484,800	\$720,000	\$726,875	\$915,625	\$1,069,375	\$1,378,750	\$1,796,875	\$1,928,125
32	\$0	\$173,920	\$339,654	\$499,950	\$742,500	\$748,125	\$944,375	\$1,101,875	\$1,421,875	\$1,858,125	\$1,980,625
33	\$0	\$179,060	\$349,795	\$515,100	\$765,000	\$770,625	\$973,125	\$1,134,375	\$1,465,000	\$1,919,375	\$2,033,125
34	\$0	\$184,200	\$359,936	\$530,250	\$787,500	\$793,125	\$1,001,875	\$1,166,875	\$1,508,125	\$1,980,625	\$2,085,625
35	\$0	\$189,340	\$370,077	\$545,400	\$810,000	\$815,625	\$1,030,625	\$1,199,375	\$1,551,250	\$2,041,875	\$2,138,125
36	\$0	\$194,480	\$380,218	\$560,550	\$832,500	\$838,125	\$1,059,375	\$1,231,875	\$1,594,375	\$2,103,125	\$2,190,625
37	\$0	\$199,620	\$390,359	\$575,700	\$855,000	\$860,625	\$1,088,125	\$1,264,375	\$1,637,500	\$2,164,375	\$2,243,125
38	\$0	\$204,760	\$400,500	\$590,850	\$877,500	\$883,125	\$1,116,875	\$1,296,875	\$1,680,625	\$2,225,625	\$2,295,625
39	\$0	\$209,900	\$410,641	\$606,000	\$900,000	\$905,625	\$1,145,625	\$1,329,375	\$1,723,750	\$2,286,875	\$2,348,125
40	\$0	\$215,040	\$420,782	\$621,150	\$922,500	\$928,125	\$1,174,375	\$1,361,875	\$1,766,875	\$2,348,125	\$2,400,625
41	\$0	\$220,180	\$430,923	\$636,300	\$945,000	\$950,625	\$1,203,125	\$1,394,375	\$1,810,000	\$2,409,375	\$2,453,125
42	\$0	\$225,320	\$441,064	\$651,450	\$967,500	\$973,125	\$1,231,875	\$1,426,875	\$1,853,125	\$2,470,625	\$2,505,625
43	\$0	\$230,460	\$451,205	\$666,600	\$990,000	\$995,625	\$1,260,625	\$1,459,375	\$1,896,250	\$2,531,875	\$2,558,125
44	\$0	\$235,600	\$461,346	\$681,750	\$1,012,500	\$1,018,125	\$1,289,375	\$1,491,875	\$1,939,375	\$2,592,500	\$2,610,625
45	\$0	\$240,740	\$471,487	\$696,900	\$1,035,000	\$1,040,625	\$1,318,125	\$1,524,375	\$1,982,500	\$2,653,750	\$2,663,125
46	\$0	\$245,880	\$481,628	\$712,050	\$1,057,500	\$1,063,125	\$1,346,875	\$1,556,875	\$2,025,625	\$2,714,375	\$2,715,625
47	\$0	\$251,020	\$491,769	\$727,200	\$1,080,000	\$1,085,625	\$1,375,625	\$1,589,375	\$2,068,750	\$2,775,625	\$2,768,125
48	\$0	\$256,160	\$501,910	\$742,350	\$1,102,500	\$1,108,125	\$1,404,375	\$1,621,875	\$2,111,875	\$2,836,875	\$2,820,625
49	\$0	\$261,300	\$512,051	\$757,500	\$1,125,000	\$1,130,625	\$1,433,125	\$1,654,375	\$2,155,000	\$2,898,125	\$2,873,125
50	\$0	\$266,440	\$522,192	\$772,650	\$1,147,500	\$1,153,125	\$1,461,875	\$1,686,875	\$2,198,125	\$2,959,375	\$2,925,625
51	\$0	\$271,580	\$532,333	\$787,800	\$1,170,000	\$1,173,625	\$1,490,625	\$1,719,375	\$2,241,250	\$3,020,625	\$2,978,125
52	\$0	\$276,720	\$542,474	\$802,950	\$1,192,500	\$1,198,125	\$1,519,375	\$1,751,875	\$2,284,375	\$3,081,875	\$3,030,625
53	\$0	\$281,860	\$552,615	\$818,100	\$1,215,000	\$1,218,625	\$1,548,125	\$1,784,375	\$2,327,500	\$3,143,125	\$3,083,125
54	\$0	\$287,000	\$562,756	\$833,250	\$1,237,500	\$1,243,125	\$1,576,875	\$1,816,875	\$2,370,625	\$3,204,375	\$3,135,625
55	\$0	\$292,140	\$572,897	\$848,400	\$1,260,000	\$1,264,375	\$1,605,625	\$1,849,375	\$2,413,750	\$3,265,625	\$3,188,125
56	\$0	\$297,280	\$583,038	\$863,550	\$1,282,500	\$1,288,125	\$1,634,375	\$1,881,875	\$2,456,875	\$3,326,875	\$3,240,625
57	\$0	\$302,420	\$593,179	\$878,700	\$1,305,000	\$1,309,625	\$1,663,125	\$1,914,375	\$2,499,375	\$3,388,125	\$3,293,125
58	\$0	\$307,560	\$603,320	\$893,850	\$1,327,500	\$1,332,125	\$1,691,875	\$1,946,875	\$2,542,500	\$3,449,375	\$3,345,625
59	\$0	\$312,700	\$613,461	\$909,000	\$1,350,000	\$1,355,625	\$1,720,625	\$1,979,375	\$2,585,625	\$3,510,625	\$3,398,125
60	\$0	\$317,840	\$623,602	\$924,150	\$1,372,500	\$1,378,125	\$1,749,375	\$2,011,875	\$2,628,750	\$3,571,875	\$3,450,625
61	\$0	\$322,980	\$633,743	\$939,300	\$1,395,000	\$1,399,625	\$1,778,125	\$2,044,375	\$2,671,875	\$3,633,125	\$3,503,125
62	\$0	\$328,120	\$643,884	\$954,450	\$1,417,500	\$1,414,375	\$1,806,875	\$2,076,875	\$2,715,000	\$3,694,375	\$3,555,625
63	\$0	\$333,260	\$654,025	\$969,600	\$1,440,000	\$1,438,125	\$1,835,625	\$2,109,375	\$2,758,125	\$3,755,625	\$3,608,125
64	\$0	\$338,400	\$664,166	\$984,750	\$1,462,500	\$1,458,375	\$1,864,375	\$2,141,875	\$2,801,250	\$3,816,875	\$3,660,625
65	\$0	\$343,540	\$674,307	\$999,900	\$1,485,000	\$1,478,625	\$1,893,125	\$2,174,375	\$2,844,375	\$3,878,125	\$3,713,125
66	\$0	\$348,680	\$684,448	\$1,015,050	\$1,507,500	\$1,498,875	\$1,921,875	\$2,206,875	\$2,887,500	\$3,939,375	\$3,765,625
67	\$0	\$353,820	\$694,589	\$1,030,200	\$1,530,000	\$1,519,125	\$1,950,625	\$2,239,375	\$2,930,625	\$4,000,625	\$3,818,125
68	\$0	\$358,960	\$704,730	\$1,045,350	\$1,552,500	\$1,539,375	\$1,979,375	\$2,271,875	\$2,973,750	\$4,061,875	\$3,870,625
69	\$0	\$364,100	\$714,871	\$1,060,500	\$1,575,000	\$1,559,625	\$2,008,125	\$2,304,375	\$3,016,875	\$4,123,125	\$3,923,125
70	\$0	\$369,240	\$725,012	\$1,075,650	\$1,597,500	\$1,579,875	\$2,036,875	\$2,336,875	\$3,059,375	\$4,184,375	\$3,975,625
71	\$0	\$374,380	\$735,153	\$1,090,800	\$1,620,000	\$1,599,625	\$2,065,625	\$2,369,375	\$3,102,500	\$4,245,625	\$4,028,125
72	\$0	\$379,520	\$745,294	\$1,105,950	\$1,642,500	\$1,619,875	\$2,094,375	\$2,401,875	\$3,145,625	\$4,306,875	\$4,080,625
73	\$0	\$384,660	\$755,435	\$1,121,100	\$1,665,000	\$1,640,125	\$2,123,125	\$2,434,375	\$3,188,750	\$4,368,125	\$4,133,125
74	\$0	\$389,800	\$765,576	\$1,136,250	\$1,687,500	\$1,660,375	\$2,151,875	\$2,466,875	\$3,231,875	\$4,429,375	\$4,185,625
75	\$0	\$394,940	\$775,717	\$1,151,400	\$1,710,000	\$1,680,625	\$2,180,625	\$2,499,375	\$3,275,000	\$4,490,625	\$4,238,125
76	\$0	\$400,080	\$785,858	\$1,166,550	\$1,732,500	\$1,700,875	\$2,209,375	\$2,531,875	\$3,318,125	\$4,551,875	\$4,290,625
77	\$0	\$405,220	\$795,999	\$1,181,700	\$1,755,000	\$1,721,125	\$2,238,125	\$2,564,375	\$3,361,250	\$4,613,125	\$4,343,125
78	\$0	\$410,360	\$806,140	\$1,196,850	\$1,777,500	\$1,741,375	\$2,266,875	\$2,596,875	\$3,404,375	\$4,674,375	\$4,395,625
79	\$0	\$415,500	\$816,281	\$1,212,000	\$1,800,000	\$1,761,625	\$2,295,625	\$2,629,375	\$3,447,500	\$4,735,625	\$4,448,125
80	\$0	\$420,640	\$826,422	\$1,227,150	\$1,822,500	\$1,781,875	\$2,324,375	\$2,661,875	\$3,490,625	\$4,796,875	\$4,500,625
81	\$0	\$425,780	\$836,563	\$1,242,300	\$1,845,000	\$1,802,125	\$2,353,125	\$2,694,375	\$3,533,750	\$4,858,125	\$4,553,125
82	\$0	\$430,920	\$846,704	\$1,257,450	\$1,867,500	\$1,822,375	\$2,381,875	\$2,726,875	\$3,576,875	\$4,919,375	\$4,605,625
83	\$0	\$436,060	\$856,845	\$1,272,600	\$1,890,000	\$1,842,625	\$2,410,625				

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Happy Holidays from CAHIP-Orange County!



Don't Forget to Register...

Pizza Party, November 15
Holiday Cruise, December 13
Legal Update, January 13
Sales Symposium, February 11

Register at: www.cahipoc.org

WHAT IS THE **ANNUAL VALUE** OF NABIP MEMBERSHIP?



Happy Holidays From CAHJP-OC Board of Directors!





How to get more value from your NABIP membership

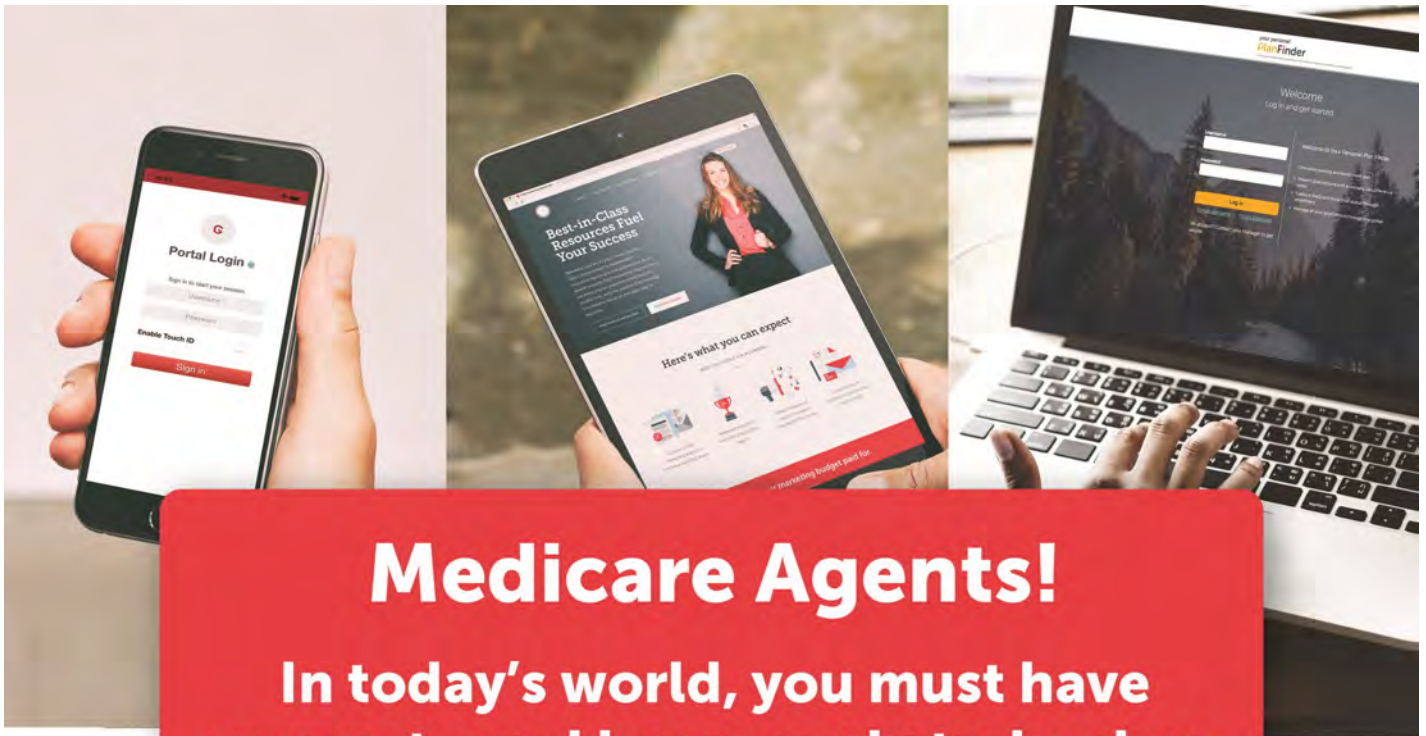
The activities below provide a blueprint for extracting the greatest value from your membership:

- Visit NABIP's Micro Site - www.welcometonabip.org
- Take advantage of NABIP's **Mentorship Program**
- Read America's Benefit Specialist Magazine each month and learn something new
- Listen to the NABIP **Healthcare Happy Hour Podcasts** on a weekly basis for up-to-date talking points
- Attend the NABIP **Power Hour** webinar monthly for in depth topic discussions and socialize with fellow members
- Attend Local Chapter meetings for opportunities to learn and network
- Volunteer to serve on a committee (Membership, Social, Programs/Expo, Legislative, etc.)
- Recruit one new member – best way to learn is to teach someone else about the NABIP value proposition
- Meet with a NABIP Board member and find out what motivates them to give their time and money
- Attend Day on the Hill and meet with your state legislators to discuss bills you support or oppose
- Attend NABIP Capitol Conference – annual legislative fly-in to Washington DC (IMPORTANT ONE)
- Attend NABIP Annual Convention to meet members from across the country and vote for NABIP incoming Secretary and other membership matters
- Contribute to NABIP-PAC – Political Action Committee contributions help us to have our voice heard on legislative issues at the national and state level. Contribute monthly to each!
- Participate in Operation Shout – click and sign letters to **your** elected officials regarding important grass roots efforts
- Earn your **Registered Employee Benefits Consultant** designation - acquired from The American College
- Complete all 12 modules of the **Leadership Academy**.
- Sign up to receive **Broker 2 Broker** emails on NABIP.org where you can post questions and respond to fellow members from around the country
- Share with your clients that you are a member of NABIP and working to protect their access to private health insurance and other benefits!

More information at www.nabip.org



Earning the Registered Employee Benefits Consultant® (REBC®) designation elevates your credibility as a professional. The field of employee benefits continues to evolve rapidly. A year does not go by without new government regulations, new or modified coverages, and new techniques for controlling benefit costs. To best serve their clients, professionals need to have a current understanding of the provisions, advantages, and limitations 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 program 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. **Earn yours now!**



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ANNUAL LEGISLATIVE UPDATE - JANUARY 14, 2025

CAHIP-OC SALES SYMPOSIUM - FEBRUARY 11, 2025

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