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County of Orange Insurance News

NABIP
2023 Pacesetter Award

ERISA Turns 50; Health Plan Compliance and ERISA Updates and Reminders

Also inside this issue

- *Legal Briefs from Marilyn Monahan, Monahan Law Office*
- *CAHIP-OC CE Day September 10, 2024*
- *Senior Summit 2024 Recap and Photos*
- *Tax Write-Offs on Cafeteria Plans vs Income Tax Returns*
- *The Hidden Costs: How Ultra-Processed Foods Affect Health and Insurance*

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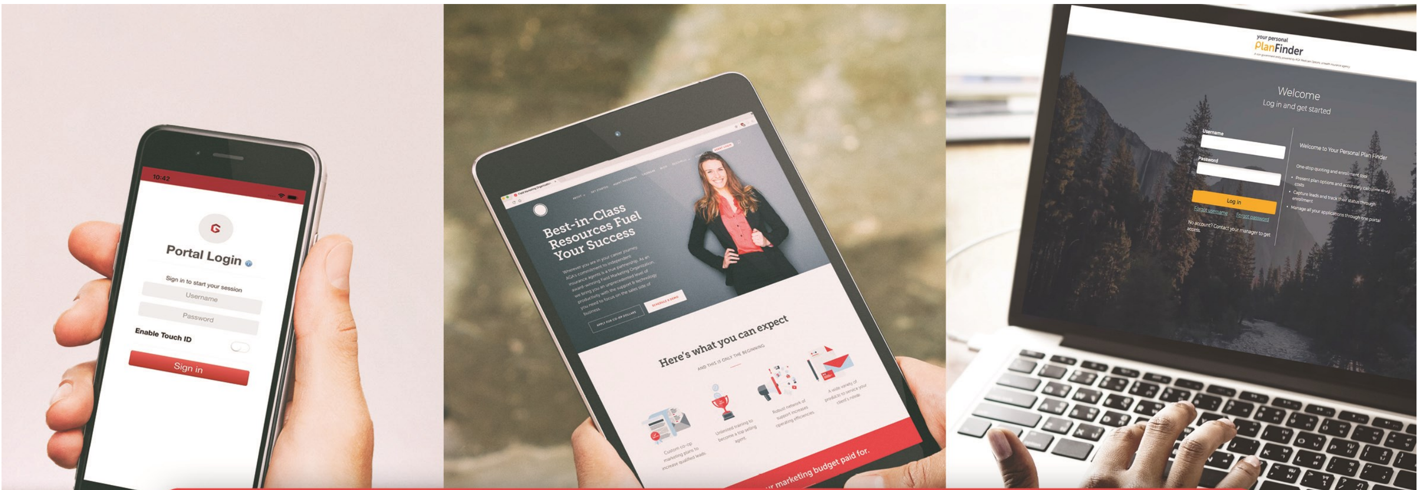

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TABLE OF CONTENTS

Thank you for being a part of CAHIP-OC!

What's Inside

CAHIP Orange County

The C.O.I.N.

CAHIP Orange County

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.

CAHIP-ORANGE COUNTY'S
PRESIDENT'S MESSAGE

By: Barbara Ciudad

Dear Members,

We're thrilled to announce an exciting lineup of events coming your way, and we wanted to take a moment to share just how valuable these gatherings will be. Whether you're a long-time member or new to our community, there's something for everyone on the horizon, and we hope you'll join us!

In today's fast-paced world, it's easy to lose touch. Our upcoming events offer a fantastic chance to connect and reconnect with fellow members, enrich your knowledge through engaging speakers and talks, and enjoy unique, memorable experiences. Beyond just having fun, these gatherings are designed to strengthen our community by fostering valuable connections and shared experiences. Your participation not only makes these events more enjoyable but also helps build a vibrant, supportive environment where everyone can thrive.

We've lined amazing events, seminars, and talks designed to broaden your horizons and deepen your understanding of various topics. Our expert speakers are eager to share their knowledge and insights, and attending these events will not only keep you informed but also inspire new ideas and perspectives.

Mark your calendars and stay tuned for detailed information about each event. We encourage you to RSVP as soon as possible to secure your spot and ensure we can accommodate everyone comfortably. Don't hesitate to reach out if you have any questions or need assistance with registration.

Let's come together to make these gatherings memorable and enriching for all. Thank you for being a valued member of our community. Your participation is what makes our events successful and our community strong. We look forward to seeing you soon!

Barbara Ciudad

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Mark Your Calendars for Our Upcoming CAHIP-OC Programs!

October 8, 2024

Cybersecurity & Ethics CE Panel with Adriana Mendieta and Miguel Villegas

November 8, 2024

November Membership Evening Event

December 13, 2024

Holiday Lights Cruise Event

(information below)

Feature Article:

ERISA Celebrates its 50th Birthday; Let's Celebrate By Being ERISA Compliant!

By: Dorothy Cociu, RHU, REBC, GBA, RPA, LPRT
CAHIP-OC VP of Communications & Public Affairs

Background and Historical Information of ERISA
Historians will remember that President Gerald R Ford signed the Employee Income Retirement Security Act on September 2, 1974. That means that we are celebrating ERISA's 50th birthday this month!

So, what's the big deal and why do we need to celebrate the 50th birthday of ERISA? *Because it has been the most important federal law that protects group benefit plans in United States' history.* And if you or your clients are self-funded, it is basically the group benefits "Bible," as I've called it in a previous article. The goal of Title I of ERISA, according to the EBSA website, is to protect the interests of participants and their beneficiaries in employee benefit plans. Among other things, ERISA requires that sponsors of private employee benefit plans provide participants and beneficiaries with adequate information regarding their plans. This may be cumbersome for employers and brokers assisting them, but it provides for consistency and order within the administration of pension and health plans. It's important to keep in mind that those individuals who manage plans (and other fiduciaries) must meet certain standards of conduct, which is required of all fiduciaries. The law also contains detailed provisions for reporting to the government and disclosure to participants. And of course, there are civil enforcement provisions aimed at assuring that plan funds are protected and that participants who qualify receive their benefits. Protection of plan assets has been one of the most important aspects of ERSIA.

The Employee Benefits Security Administration (EBSA) is responsible for administering and enforcing the fiduciary, reporting and disclosure provisions of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Until February 2003, EBSA was known as the Pension and Welfare Benefits Administration (PWBA). Prior to January 1986, PWBA was known as the Pension and Welfare Benefits Program

ERISA is massive, but the provisions of Title I of ERISA, which are administered by the U.S. Department of Labor, were enacted to address public concern that funds of private pension plans were being mismanaged and abused. ERISA was the culmination of a long line of legislation concerned with the labor and tax aspects of employee benefit plans. Since its enactment in 1974, ERISA has been amended many times to meet the changing retirement and health care needs of employees and their families.

Because it's so massive and has so many implications, the administration of ERISA is divided among the U.S. Department of Labor, the Internal Revenue Service of the Department of the Treasury (IRS), and the Pension Benefit Guaranty Corporation (PBGC). Title I, which contains rules for reporting and disclosure, vesting, participation, funding, fiduciary conduct, and civil enforcement, is administered by the U.S. Department of Labor. Title II of ERISA, which amended the Internal Revenue Code to parallel many of the Title I rules, is administered by the IRS. Title III is concerned with jurisdictional matters and with coordination of enforcement and regulatory activities by the U.S. Department of Labor and the IRS. Title IV covers the insurance of defined benefit pension plans and is administered by the PBGC.

It hasn't always been so clearly defined as to what department does what to protect ERISA. Prior to a 1978 reorganization, there was overlapping responsibility for administration of the parallel provisions of Title I of ERISA and the tax code by the U.S. Department of Labor and the IRS, respectively. As a result of this reorganization, the U.S. Department of Labor has primary responsibility for reporting, disclosure and fiduciary requirements; and the IRS has primary responsibility for participation, vesting and funding issues. Importantly, the U.S. Department of Labor may intervene in any matters that materially affect the rights of participants, regardless of primary responsibility. This dual responsibility of federal Departments provides for more comprehensive administration (and auditing capabilities) than if a single Department had responsibility.

I asked Marilyn Monahan of Monahan Law Office how much she thinks ERISA has changed over the past 50 years related to health plans? "I think it is fair to say that ERISA has changed dramatically since it was first enacted," Marilyn stated. "In the health and welfare arena, COBRA, HIPAA, the ACA, and the CAA have added significantly expanded benefits and protections for employees."

What Does ERISA Do and Why Does it Exist?
ERISA covers retirement plans (including traditional defined benefit pension plans and individual account plans such as 401(k) plans) and welfare benefit plans (e.g., employment based medical and hospitalization benefits, apprenticeship plans, and other plans described in section 3(1) of Title I). Plan sponsors must design and administer their plans in accordance with ERISA. Title II of ERISA

Continued on page 13

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Happy 50th Birthday, ERISA!

ERISA turns the big 50 on September 2nd! Let's celebrate ERISA hitting the mid-century mark by getting to know ERISA better, and the Monahan Law Office can help.

The Monahan Law Office offers a range of ERISA compliance services:

- Plan documents and wraps
- Training and webinars
- Translation of legalese into layperson terms
- Help with employee questions and communications
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The Monahan Law Office brings two decades of mastery to the table, adeptly navigating ERISA, ACA, COBRA, HIPAA, and CAA regulatory requirements. Let us be your benefits resource. Let us help you solve your compliance conundrums.

Marilyn A. Monahan | Monahan Law Office
4712 Admiralty Way, #349, Marina del Rey, California 90292
(310) 989-0993 | marilyn@monahanlawoffice.com

CAHIP Orange County

See Pages 24 & 25 For More Information!

CE DAY

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8:30 AM TO 4:00 PM

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- **TRACK 1:** INDIVIDUAL MARKET Including Medicare
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Lake Forest, CA 92630

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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

This is a summary of some important reminders for, as well as recent developments of interest to, consultants and employers— including reminders about some very important deadlines and issues to keep in mind as we approach open enrollment season:

FEDERAL: HIGHLIGHTS

Affordable Care Act (ACA) Affordability Percentage: As of the date this article went to print, the IRS had not yet announced the ACA affordability percentage for the 2025 plan year. The announcement usually comes out at the beginning of September.

"Applicable large employers" (ALEs) will want to ensure that, using the affordability percentage and the affordability safe harbor methodologies developed by the IRS, the amount employers ask employees to contribute toward the cost of self-only coverage is considered "affordable." If the coverage is not affordable, the employer could be assessed a penalty under Internal Revenue Code (IRC) section 4980H (b). In addition, if the ALE does not offer coverage to at least 95% of its full-time employees, the employer could be assessed a penalty under section 4980H(a).

HIPAA/HHS/OCR Updates

Important Note: Due to the length of Marilyn's Legal Brief and other longer than expected articles this issue, I am going to hold my HIPAA updates until the next issue! Marilyn included much of my information in her Legal Briefs! Coming next issue!

Legal Briefs, Continued

Section 4980H Payments: The IRS announced the section 4980H(a) and (b) penalties for 2025--and they are decreasing (a first)! For 2025, the 4980H(a) penalty is $2,900 and the 4980H(b) penalty is $4,350.

2024 Forms 1094/1095: The IRS has not yet issued final versions of the Forms 1094/1095. The updated forms must be distributed to employees and filed with the IRS in early 2025. Failure to timely distribute or file the forms could cause the IRS to impose penalties:

2024 Forms 1094/1095 Penalties

Returns Due	Penalty Rate	Not More Than 30 Days	31 Days Late Thru August 1	After August 1	Intentional Disregard
From 01-01-2025 thru 12-31-2025	Per return/ max	$60/ $664,500	$130/ $1,993,500	$330/ $3,987,000	$660/ No max
From 01-01-2024 thru 12-31-2024	Per return/ max	$60/ $630,500	$120/ $1,891,500	$310/ $3,783,000	$630/ No max
From 01-01 2023-12-31-23	Per return/ max	$50/ $588,500	$110/ $1,766,000	$290/ $3,532,500	$580/ No max

Continued on page 9

These same penalties could apply if the forms are distributed and filed on time, but they contain inaccurate or incomplete information.

Medicare Part D Creditable Coverage: There has been a change in Medicare coverage limits for 2025 that may impact plan design choices employers make for the new year.

Some background is in order. Medicare-eligible individuals who enroll in employer-sponsored plans with creditable prescription drug coverage will not pay a penalty when they ultimately enroll in a Medicare Part D prescription drug plan. So that they know if the coverage they are being offered by the employer is creditable or not, employers must provide a notice to these individuals each year. The Centers for Medicare & Medicaid Services (CMS) makes model notices available for use by employers.

The creditable/non-creditable coverage notices must be distributed before October 15th, the start of the annual Medicare open enrollment period. Many employers treat October 14 as the last day to send out the notices, but this year October 14 falls on a Monday, and that Monday is a federal holiday. Therefore, employers should distribute the notices no later than Friday, October 11.

However, there is a good reason for certain employers to send the creditable/non-creditable coverage notices earlier this year, and not wait until mid-October. CMS has announced that the maximum out-of-pocket limit for Medicare Part D plans in 2025 will be $2,000—which is significantly lower than the maximum out-of-pocket limit for 2024. As a result, it is possible that some employer prescription drug plans that qualified as creditable for 2024 will not qualify as creditable for 2025 (such as certain high deductible health plans). Some employers may decide to change their plan designs for 2025 as a result. Remember that employers do not have to offer creditable coverage, but often aim to do so for the benefit of their Medicare-eligible employees. In the event, however, that the coverage is not creditable, employees will want to know this well in advance of the Medicare open enrollment period so that, if they choose, they can make alternative coverage choices to avoid potential penalties under Medicare Part D.

Summary of Benefits and Coverage (SBC) and Claim Forms: Revisions: SBCs and claim forms are being revised for 2025. Why are these changes occurring?

Under the ACA, non-grandfathered plans must provide SBCs and claim forms in a "culturally and linguistically appropriate manner." To satisfy this mandate, when SBCs and claim forms are sent to an address in a county where 10% or more of the population is literate only in the same non-English language, the forms must be provided with a translated tagline explaining that assistance is available in that non-English language. In addition, if a translated document is requested, it must be provided. Under existing rules, taglines and SBCs must be translated into 4 languages (Spanish, Chinese, Tagalog, and Navajo) because certain counties in the United States meet the 10% threshold for those languages.

In 2023, the Departments of Labor, Treasury, and Health and Human Services (the Departments) issued updated data on which counties in the United States meet the 10% threshold (the 2023 CLAS Guidance). Some California counties which were previously on the list—such as Orange and San Diego—are no longer on the list; in other cases, counties were added to the list. Further, in addition to the 4 languages previously identified, taglines may have to be provided in 4 additional languages (Pennsylvania Dutch, Samoan, Carolinian, and Chamorro). Sample taglines in all 8 languages have already been provided by the Departments.

In addition to providing the new taglines, the Departments have announced that they intend to update the following sample documents:

- SBC template and sample completed SBCs in English (with updated taglines in the applicable non-English languages);
- Additional translated versions of the SBC and Uniform Glossary; and
- Model notices for internal claims and appeals and external review (with updated taglines in applicable non-English languages).

When do these new standards have to be met? Plans must comply for the plan year beginning on or after January 1, 2025, so this change impacts calendar year plans. If the plan is fully insured, the insurer will prepare the updated forms (but the employer must distribute the SBCs). If the plan is self-funded, the employer must work with its TPA or ASO to prepare updated SBCs and claim forms (and the employer must then distribute the SBCs).

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule: The Office for Civil Rights (OCR), within HHS, has issued a new final rule that amends the HIPAA Privacy Rule. The goal is to protect data that falls under the new definition of "reproductive health care."

Continued on page 10

Legal Briefs, Continued from Page 9

Under the new rule, a covered entity or business associate is prohibited from using or disclosing "protected health information" (PHI) for the following activities:

(1) To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.

(2) To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.

(3) To identify any person for any purpose described in (1) or (2).

The prohibition applies where a covered entity or business associate has reasonably determined that one or more of the following conditions exists:

- The reproductive health care is lawful under the law of the state in which such health care is provided under the circumstances in which it is provided.

- The reproductive health care is protected, required, or authorized by Federal law, including the U.S. Constitution, regardless of the state in which such health care is provided.

- The reproductive health care was provided by a person other than the covered entity or business associate that receives the request for PHI and the presumption of lawfulness (described in the rule) is satisfied.

The revisions to the Privacy Rule explain that PHI potentially related to reproductive health care may be disclosed if it is not for one of the purposes noted above, and the covered entity receives a signed "attestation" that the use or disclosure of PHI is not for a prohibited purpose. This attestation requirement applies when the request for PHI is for any of the following purposes: Health oversight activities; judicial and administrative proceedings; law enforcement purposes; and disclosures to coroners and medical examiners about decedents.

OCR has issued a model attestation. The regulations contain very specific rules on the content and format of the attestation.

What is the effective date of the final rule? The changes took effect on June 25, 2024; covered entities and business associates must comply by December 23, 2024. In addition, Notices of Privacy Practices must be amended by February 16, 2026 (which is the same date that amendments to the Notice of Privacy Practices are required to reflect the new final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations).

In addition to updating the Notice of Privacy Practices and implementing the new restrictions, covered entities and business associates should update, as necessary, their policy and procedure manuals, business associate contracts, and plan documents.

HIPAA Civil Monetary Penalties: The Department of Health and Human Services (HHS), has announced annual increases to penalties for violations of HIPAA. The increased penalty amounts are effective for penalties assessed on or after August 8, 2024, for violations occurring on or after November 2, 2015. The adjusted amounts are:

Violation Category	Each Violation	All Such Violations of an Identical Provision in a Calendar Year (Annual Maximum)
(A) Did not know	$141-$71,162	$2,134,831
(B) Reasonable	$1,424-$71,162	$2,134,831
(C)Willful Neglect—Corrected within 30 days	$14,232-$71,162	$2,134,831
(D) Willful Neglect—Not Correct-	$71,162-$2,134,831	$2,134,831

Medicare Secondary Payer (MSP): Penalties: HHS also announced increased penalties for violations of the MSP rules. Under the MSP rules, group health plans are prohibited from "taking into account" that an individual is entitled to Medicare on the basis of age, end-stage renal disease (ESRD), or disability. In addition, employers cannot offer Medicare beneficiaries financial or other benefits as incentives not to enroll in, or terminate enrollment in, a group health plan that would otherwise be primary to Medicare. Effective August 8, 2024, the penalty for offering an incentive has increased from $11,162 to $11,524. (Other MSP penalties were also increased but are

Continued on page 12

Don't Forget Our Upcoming Programs!

CE Day
September 10, 2024
8:30 AM to 4:00 PM
Lake Forest Community Center

Cyber Risk, Security & Ethics CE
CE Course Number 390236
Featuring Adriana Mendieta and Miguel Villegas
October 8, 2024
Lake Forest Community Center

Legal Briefs, Continued from page 10

not summarized here.)

Summary of Benefits and Coverage (SBC): Penalties: Finally, HHS announced that, effective August 8, 2024, the penalty for failure to provide an SBC has increased to $1,406 for each failure (previously the penalty was $1,362).

Educational Assistance Programs: The Consolidated Appropriations Act, 2021 (CAA) amended section 127 of the Internal Revenue Code to allow employers to set up Educational Assistance Programs that reimburse employees for qualified student loan debt. (Such programs can also be set up to reimburse tuition expenses.) To qualify, the expenses must be incurred before **2026** (although Congress is looking at legislation that would extend the benefit beyond 2026). Also, the reimbursement cannot exceed $5,250. The benefit is tax free to employees, meaning employer payments are not included in the employee's gross income. Employers have to follow certain rules in order to properly set up such a program, including having a written plan document.

It is important to know that the California legislature has not passed conforming legislation. This means that the tax break that is available at the federal level is not also available at the state level in California.

The IRS recently issued FAQs to help guide employers on the implementation of these plans. In addition, the IRS posted a sample plan document (Publication 5993). The FAQs are available at this link: ***https://www.irs.gov/newsroom/frequently-asked-questions-about-educational-assistance-programs***

CALIFORNIA: HIGHLIGHTS

S.B. 828, Durazo. Minimum Wages: Health Care Workers: Delay (Chapter 12): As we reported in the last issue of C.O.I.N., in 2023 the legislature passed and the governor signed a bill that will increase the hourly wage for health care workers starting on June 1, 2024 (S.B. 525). Then, on May 31, 2024, Govern Newsom signed S.B. 828. This new bill, which took effect immediately as an urgency measure, delayed the start date of the wage increase for one month, from June 1 to July 1, 2024. The delay "align[s] the healthcare worker minimum wage provisions with the state budget timeline and allows the Legislature and the Governor to continue" discussions about additional changes to the terms of S.B. 525. S.B. 828 also specifies that future annual increases in the minimum wage required by S.B. 525 will take effect on July 1 rather than June 1.

But there is another new development: another bill was signed into law which again delays the start of the minimum wage increase again:

S.B. 159, Committee on Budget and Fiscal Review. Health (Chapter 40): On June 29th, Governor Newsom signed S.B. 159, which delays the minimum wage increase originally added by S.B. 525 to at least October 15, 2024. The amendments put in place by S.B. 159 delay the implementation of the health care minimum wage until one of the following occurs:

- If the Department of Finance determines that agency cash receipts from July 1 through September 30, 2024, are at least three percent higher than projected at the time of the enactment of the 2024 Budget Act, then the effective date of the wage increase will be October 15, 2024.
- If the Department of Health Care Services initiates the data retrieval necessary to implement an increase to the hospital quality assurance fee revenues beginning January 1, 2025, then the effective date of the wage increase will be the earlier of January 1, 2025, or 15 days after the notification to the Joint Legislative Budget Committee.

CalSavers: Under the CalSavers program, eligible employers must either offer their eligible employees a qualified retirement plan or register with CalSavers. Registration with CalSavers then allows employees to save through the CalSavers retirement program. The requirements are the same for non-profit and for-profit employers, but do not apply to government employers.

Implementation has been staggered, and for many California employers the compliance deadline has already passed. However, and importantly, as a result of a 2022 bill signed into law by Governor Newsom (S.B. 1126), a new category of employers will be subject to the CalSavers' mandate soon: effective December 31, 2025, employers with 1 or more employees must comply.

S.B. 1126 added an important exclusion: the definition of eligible employers does not include "sole proprietorships, self-employed individuals, or other business entities that do not employ any individuals other than the owners of the business." Even with this limitation, this change in the law will mean many more employers, by the end of 2025, will either have to offer their employees a qualified retirement plan or participate in the CalSavers program. As small employers plan for 2025, they may need to add CalSavers to their "to-do" list.

The implementation dates for CalSavers are as follows:

Size of Business	Deadline
Over 100 Employees	September 30, 2020
Over 50 Employees	June 30, 2021
5 or More	June 30, 2022
1 or More	December 31, 2025

Continued on page 20

Feature Article, ERISA's 50th Birthday, Continued from Page 5

contains standards that must be met by employee retirement benefit plans in order to qualify for favorable tax treatment. Noncompliance with these tax qualification requirements of ERISA may result in disqualification of a plan and/or other penalties for tax purposes. These tax qualifications, or allowance for tax deductions, are one of the primary reasons employers offer group health and pension plans.

I asked Marilyn how important the passage of ERISA was to employee benefits in general? "ERISA was a game changer," stated Marilyn. "It put into place a comprehensive system designed to enhance the integrity and reliability of pension and health and welfare benefit plans offered by employers to their employees. It accomplished this through various mechanisms, including the creation of new transparency, disclosure, and vesting rules, along with the Pension Benefit Guaranty Corporation (PBGC). While ERISA did impose new administrative burdens on employers, it also created a national standard for administration—so that employers do not have to contend with 50 different sets of state rules—and it encouraged employers to offer benefits by limiting their potential liability."

ERISA Fiduciary Duties- Summary
There are four main fiduciary duties under ERISA: 1) the Duty of undivided loyalty to plan participants and beneficiaries (exclusive benefit rule), including acting for the sole purpose of providing benefits to plan participants, which includes the requirement that you must only pay reasonable plan expenses; 2) Duty of prudence (Prudent Man/Person Standard of Care). ERISA requires that plan fiduciaries must act with the care, skill, prudence, and diligence under the circumstances then prevailing, that any prudent person acting in a like capacity and familiar with such matters would use. What has now been added to these duties is an obligation to ensure "proper mitigation of cybersecurity risks." 3) Duty to diversify assets of the plan; 4) Duty to administer the plan in conformity with governing documents. The DOL understands and encourages plan fiduciaries to get help if and when they need it from experts.

I asked Marilyn how important ERISA has been in the protection of plan participants? "Very important," she said, matter-pf-factly. "For example, the disclosure requirements ensure that participants know the scope of the benefits offered to them, and the terms and conditions under which those benefits will be made available. The transparency requirements give participants—along with the DOL—the ability to monitor the status and viability of the employer's benefit plans. ERISA also established fiduciary standards that must be followed when administering benefit plans, and established a participant's right to pursue legal action when plan fiduciaries fail to satisfy those standards. These and other provisions in ERISA give participants better protection because they ensure that the benefits they expect to receive will be there when they need them. I will finally note that EBSA's help line gives participants the opportunity to call an expert and get assistance with their questions, as well as help when they have a dispute over benefits with their employer—without having to resort to litigation.

I also asked Marilyn what she thinks are the most important ERISA compliance items people should be aware of as we celebrate it's 50th birthday? "First, employers must continue to focus on plan documentation, ensuring that the documentation is accurate, up-to-date, and easily accessible to participants," stated Marilyn. "Second, employers need to understand the responsibilities of plan fiduciaries, and ensure they are administering their benefit plans according to applicable fiduciary standards."

ERISA-Related Legislation and Amendments
Important legislation has amended ERISA and increased the responsibilities of EBSA. For example, the Retirement Equity Act of 1984 reduced the maximum age that an employer may require for participation in a retirement plan; lengthened the period of time a participant could be absent from work without losing credit towards the plan's vesting rules for pre-break years of service; and created spousal rights to retirement benefits through qualified domestic relations orders (QDROs) in the event of divorce, and through pre-retirement survivor annuities. The Omnibus Budget Reconciliation Act of 1986 eliminated the ability of employers to limit participation in their retirement plans for new employees who are close to retirement and the ability to freeze benefits for participants over age 65. The Omnibus Budget Reconciliation Act of 1989 requires the Secretary of Labor to assess a civil penalty equal to 20% of any amount recovered for violations of fiduciary responsibility. The Pension Protection Act of 2006 made many changes to ERISA, including expanding the availability of fiduciary investment advice to participants in 401(k)-type plans and individual retirement accounts (IRAs), removing impediments to automatic enrollment through qualified default investment alternatives, and increasing the transparency of pension plan funding through new notice requirements.

The department's responsibilities under ERISA have also been expanded by healthcare legislation. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added a new part 6 to Title I of ERISA which provides for the continuation of health care coverage for employees and their beneficiaries (for a limited period of time) if certain events would otherwise result in a reduction in benefits. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new Part 7 to Title I of ERISA, aimed at making health care

Continued on page 14

Feature Article, ERISA's 50th Birthday Continued from Page 13

coverage more portable and secure for employees, and gave the department broad additional responsibilities with respect to private health plans. These responsibilities were increased further with the enactment of the Newborns' and Mothers' Health Protection Act of 1996, the Mental Health Parity Act of 1996, the Women's Health and Cancer Rights Act of 1998, the Genetic Information Nondiscrimination Act of 2008, the Mental Health Parity and Addiction Equity Act of 2008, and the Children's Health Insurance Program Reauthorization Act. More recently, the 2010 passage of the Patient Protection and Affordable Care Act (ACA) brought widespread health care reform. In addition to the ACA's market reform provisions, significant changes impact dependent coverage, lifetime and annual benefit limits, coverage of preventative services, preexisting condition exclusions for minors, disclosures to plan participants, claims procedures and external review, and many other areas. The ACA also provided EBSA with additional enforcement authority to protect workers and employers whose health benefits are provided through Multiple Employer Welfare Arrangements. As the ACA phased in full implementation beginning in 2014, EBSA and the Department of Health and Human Services, the Department of the Treasury and the Internal Revenue Service have continued to work to issue guidance on the law's many provisions.

Most recently, in 2021, the Department of Labor issued Guidance on Fiduciary Responsibilities related to Cybersecurity, expanding the protections of plan participants and plan assets even more.

Plan Compliance Requirements of ERISA & Pre-Emption

Given the 50th birthday of ERISA, it's a great time to remind everyone of the plan compliance requirements under ERISA and related laws. Before I get into details, it's important to remember that ERISA requirements are Plan Sponsor requirements, not the requirements of Brokers or Consultants. However, many of us feel it is our duty and obligation to our employer clients to assist them with ERISA and related laws and regulations. It's also important to remember that failure to be compliant could result in compliance penalties, not to mention employee complaints, plan participant lawsuits, audits and more. In today's world of complex mergers and acquisitions, NOT being compliant could disrupt the deal, which affects all parties, and no one wants that.

ERISA pre-empts state laws regulating covered health plans, with the exception of state insurance laws. California insurance laws continue to apply to fully insured plans and HMOs, but self-funded health plans are regulated by ERISA and not state laws.

The types of Employee Welfare Benefit Plans for which ERISA applies includes health, dental, vision, health FSAs, HRAs, short-term disability, long-term disability, life insurance, accidental death and dismemberment coverage, pre-paid legal plans, some EAP programs and some wellness programs.

ERISA Compliance & Required Disclosures

ERISA requires a series of disclosures, including a Plan Document, a Summary Plan Description (SPD), an SBC (which came from the ACA requirements) and a series of plan participant notices. In addition, a Form 5500 filing is required for plans with 100 or more participants (more information later in this article).

ERISA states that "every employee benefit plan shall be established and maintained pursuant to a written instrument," a legal document that governs the plan, or the Plan Document (not to be confused with a Summary Plan Description, which I will discuss next).

Plan Document

The Plan Document must contain certain terms required by ERISA; items that are most commonly not included in the insurer's documents, such as a Certificate of Coverage or Evidence of Coverage (EOC). This document is allowed to be written in "the language of lawyers," although, as someone who has written many, many plan documents, I tend to write them in more plain language (similar to the SPD). However, if the plan wants to get technical and include attorney verbiage, this is the document where that should be placed, as this is the legal instrument for the plan.

Unlike the SPD, the Plan Document is not meant for distribution to plan participants, but it must be provided upon request within 30 days of such request or pay a penalty. Unlike the 5500 form, the plan document does not have a small plan exemption. Therefore, all private sector employer group plans must have a Plan Document.

In the event of an audit, the Plan Document is generally number 1 or 2 on the documentation list from the DOL.

The Plan Document must contain the following:

· Name of the plan fiduciary(ies);
· A procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of ERISA;
· A description of any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan, including any procedure for allocating or delegating fiduciary responsibilities;
· A procedure for amending the plan, and for identifying the person who has authority to amend the plan, and
· The basis

Continued on Page 15

on which payments are made to and from the plan.

Summary Plan Description (SPD)

The Summary Plan Description, or SPD, is the primary method of communicating the plan terms to the plan participants. Unlike the Plan Document, this should be written in a manner that is calculated to be understood by the average plan participant, with an objective of "clear, simple communication."

The SPD is required to comply with content regulations, style and format regulations, and foreign language regulations. It must be distributed in a manner that is "reasonably calculated to ensure actual receipt," whether that is in-person, by mail, or distributed electronically.

The SPD must include a comprehensive list of terms and provisions that are required, including the Plan Name, Plan Number, eligibility provisions, contribution information, funding sources and other content requirements. Required Notices must also be included in the SPD. It's important to note that there is guidance on this available on the DOL website: "Self-Compliance Tool for Part 7 of ERISA: Health Care Provisions." If you're involved in a DOL audit, they will look for the items described in this compliance tool, and the 5500 first (5500 if over 100 plan participants). You need to be sure to compare the language across all ERISA-required documents, and be sure that the language is clear and consistent. This includes the Plan Document, Summary Plan Description and Evidence of Coverage from carriers.

Again, the method of presentation for the SPD shall be that it is written in a manner to be understood by the plan participants and sufficiently accurate and comprehensive to reasonably notify plan participants and beneficiaries of their rights and obligations under the plan. The format must not have the effect of misleading, misinforming, or failing to inform the plan participants or beneficiaries.

Wrap Documents

Because ERISA requires a legal Plan Document and most fully insured carriers do not issue Plan Documents; they instead issue a Certificate of Coverage or Evidence of Coverage (EOC), plan sponsors can use the "Wrap" method to supply the terms and provisions required by ERISA but not necessarily included in the Certificate of Coverage or EOC. You can use a "Wrap" method for both the Plan Document and the SPD. Basically, you create a Wrap Document, which includes the ERISA-required items, and attach the insured carrier's Certificate of Coverage, EOC or other documentation, as a part of the Wrap Around Document. You can also "wrap" multiple fully insured plans/policies into one single Wrap Plan Document, so that the Plan Sponsor can have one legal plan, rather than several. For example, if a plan sponsor offers 2 medical plans from 2 carriers, a fully insured dental plan, and a vision plan, you can create a "Wrap Document" which has all of the ERISA requirements, and attach all noted/documented "plans" into the one Wrap Document. This method will reduce the number of 5500's that need filing, etc. (one plan means one 5500 filing, rather than one for each plan). If you're wrapping one or more medical, dental, and vision plans, you can include the medical EOC(s), the SBC, the dental EOC(s), the vision EOC(s), and incorporate any contribution information schedule, any benefit summaries, all of your annual notices required, etc. into the one Wrap Document.

Keep in mind, if the plan sponsor/employer is an ACA Applicable Large Employer (ALE), you can also incorporate the description of hours worked, the full-time status determination or 4980H measurement period methodology, the dependent eligibility, waiting periods, and coverage during leave terms into the Wrap Document.

Summary of Benefits and Coverage

Most employers and brokers are now very familiar with the Summary of Benefits & Coverage, or SBC requirements. It's a simple, concise explanation of benefits and is very prescriptive and recognizable (primarily due to its blue and black color combo)… All plans must be laid out in the same way for easy plan comparisons by the plan participants. They should be able to glance quickly at multiple SBCs, and since the benefits included are the same on each page, in the same order, it is easy to compare plans. That is the idea behind an SBC. They are required only for Medical coverage, and not for stand-alone dental, vision, or other benefits.

Plan Sponsors/plans must provide the SBC to all participants and all beneficiaries. In fully insured plans, the carrier will prepare the SBCs. In a self-funded plan, the Plan Administrator (the plan sponsor employer) must prepare them, or contract with someone to do them on the plan's behalf. As a self-funded plan consultant, I have prepared SBCs for my clients since their first requirement date.

The SBC must be provided in a "culturally and linguistically appropriate manner. There are penalties, of course, for failure to provide an SBC in the required format. Penalties for failure to provide an SBD in 2024 are $1,406 per failure.

SBC Use in Marketplace Appeals

An important quick fact about the SBC is that they are the major line of defense if the state or federal marketplace sends a letter to the plan sponsor regarding a Marketplace Appeal, where they state that a plan participant has received a subsidized health plan under the state or federal Marketplace (such as Covered California) which may not have been appropriate. The SBC states if the plan meets the ACA Minimum Value provisions (MV) and Minimum Essential Coverage (MEC) provisions. *I've seen instances where penalties were proposed simply because the SBC preparer did not say "YES" to those two items on the SBC. A "No" or leaving this area blank may automatically trigger a compliance penalty for the plan sponsor. If* a plan should receive a Marketplace Appeal letter from a state or federal exchange, they should be prepared to submit a copy of the SBC to see that the plan or plans offered Minimum Value and Minimum Essential Coverage and therefore, in most cases, the plan participant, if offered coverage in the group health plan, would not be eligible for a subsidy.

Amendments to the Plan

Continued on Page 16

Feature Article, ERISA's 50th Birthday, Continued from Page 15

In the event of an amendment to the plan, a Summary of Material Modification (SMM) must be provided in the event of any material modification to the plan, and any change to the information required by ERISA or the SPD content regulations. You must distribute an SMM no later than 120 days after the close of the plan year in which modifications or changes were adopted. It is always recommended that you get the SMMs out sooner rather than later. However, they are not needed if a new SPD is provided within that 120 days after the close of the plan year.

A Summary of Material Reduction (SMR) is required within 60 days of the adoption of a material reduction in covered services or benefits. The SMR applies only to group health plans. Again, like the SMM, the notice is not required if a new or restated SPD is provided. However, if the modification occurs mid-year, the plan sponsor must provide an SMR *60 days in advance of the plan modification* (assuming it is a reduction in coverage).

One thing attorneys will advise plan sponsors of is to not have a great number of plan amendments which plan participants must keep track of. When your number of plan amendments starts to grow (I've seen a rule of thumb of 6 or more amendments, but some may go as high as ten – I suggest seeking the advice of legal counsel if you have more than 6), you should instead ***restate*** the Plan Document and Summary Plan Description, or at least the SPD, as that is what the plan participants see.

Mandatory Notices & Open Enrollment Checklist of Materials

Each Plan should have an SPD, which could include a wrap SPD, the EOCs of each carrier, the SMMs, SMRs, eligibility provisions, waiting period provisions, contribution schedule for plan participants, and all other materials that are incorporated into the Wrap; a Summary of Benefits & Coverage (SBC) for the health plan; Women's Health & Cancer Rights Act notice; Newborns' and Mothers' Health Protection Act notice; a HIPAA Notice of Special Enrollment Rights; a Michelle's Law Notice; a Medicare Part D Creditable Coverage Notice; a CHIP Notice, a Cafeteria Election Form (if applicable); HIPAA & ADA Wellness Notice (if applicable); Grandfathered Plan Notice (if applicable); a Notice or Patient Protections (if applicable – due to the CAA – now applies to grandfathered plans); and a No Suprises Act Notice. Stay tuned for the new Mental Health Parity Notices.

Other items to be sure you have available are a HIPAA Notices of Privacy Practices, which are required if the plan is self-funded every three years, so the plan sponsor needs a way to track when the notices were provided, to be sure they are being distributed with Open Enrollment packets every three years, or when a change occurs to the privacy practices which affect the Notice.

The same items described above should apply to New Hire Packets; in a new hire packet, the plan participant should receive a HIPAA Notice of Privacy Practices, and the 3-year requirement will begin with that new hire date for that individual, but the plan sponsor can blend the new hire into the group's 3-year time-frame after the initial notice. New hire packets should also include an initial COBRA Notice (general notice).

Required Employer Communications

Plan sponsor employers are required to distribute the documents described above when prepared. ERISA has distribution rules for employees for the SPD, SBC and mandatory notices, using authorized methods of distribution.

ERISA requires a method reasonably calculated to ensure actual receipt of the materials. *You cannot simply leave a stack of SPDs and SBCs in the break room for employees to pick up. Employer Plan Sponsors must target their audience and determine the best way to distribute that particular population of the workforce.* For example, those who sit at desks in the office may be distributed electronically, where those working remotely or teleworking, on leave, on vacation, outside sales reps, those enrolled in COBRA coverage, etc. would need to perhaps have an alternate means of distribution. Sales reps, for example, may be determined to have ample access to computers, so may qualify for electronic distribution, where warehouse or yard employees, those on construction sites, etc. may need to have the materials mailed to their homes.

Employers must also identify those with foreign language needs.

Electronic Distribution Rules

The electronic distribution rules were written in 2002, and therefore may not reflect the current usage of employers, particularly since COVID forced many workers to work remotely, where they historically have been in the office. However, since no revised rules have been released, we must use the old rules and modify when applicable to meet the general intent of the law.

Employees who have frequent and continual access to the employer's electronic information system which is an integral part of their duties are not required to provide the employer with written consent to provide materials electronically (although many employers gain authorization anyway to protect themselves). Those employees that are out in the field, work on construction sites, etc., or those with language barriers or without the financial means to have access to electronic documents will need to provide the employer with a formal authorization to receive information electronically; but if they do this, the employer must make alternative electronic devices available to them, such as work stations or kiosks. If they do use this method, however, the Plan Sponsor should follow the rules to ensure receipt, such as using a return-receipt, conduct periodic surveys or reviews to confirm receipt, etc. Many employers require employees to login to a payroll company's website to enter their hour tracking information in order to get paid… If that is the case, the employer would be allowed to provide the electronic documents within that payroll system, but they should set up a receipt verification within the software, so that the employee has to verify receipt of the materials. In addition, if these alternate methods are used, employers should furnish a paper

Continued on page 17

copy of all materials upon request, at no charge to the employee or plan participant.

ERISA Reporting Requirements

Form 5500: The plan Administrator of an ERISA plan must file an "annual report" known as the Form 5500. This requirement applies to plan sponsors with 100 or more plan participants at the beginning of the plan year. There is a small plan exception for the Form 5500 for plans with fewer than 100 participants. This small plan exception applies only to the Form 5500 and not to other ERISA mandates. The form 5500 is due by the last day of the 7th month after the end of the plan year; therefore, January 1 plan years must file by July 31.

How many form 5500s need to be filed depends on the number of ERISA plans the plan sponsor has. As discussed above under Wrap Documents, if the plan sponsor "wraps" multiple plans into one plan, then they need only file one Form 5500. Plan sponsors must be cautious so that they do not duplicate plan numbers. The first ERISA plan established should be numbered Plan Number 501. This could have occurred with a pension plan, however, so be sure to check all other ERISA plans, whether a medical, dental, vision, or retirement plan to verify that you're not duplicating plan number 501. Other plans can be numbered 502, 503, and so on.

In the event of an audit, one of the first two items that the auditors will look at is the Form 5500. The Plan Document is the other most requested document (either are one or two on the list).

Failure to file a Form 5500 could result in a penalty of $2,670/day ($37 per participant) in 2024 for failure to file a timely filing. There is a Delinquent Filer Voluntary Compliance Program window (DFVCP) available. Note that Form 5500 EZ or Form 5500-SF are not eligible to file under the DFVCP.

For more information on the DFVCP, you can refer to the Fact Sheet at: *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/dfvcp.pdf*.

There is also a requirement for an SAR, or Summary Annual Report. The SAR, unlike the 5500, must be distributed to the plan participants within 9 months after the plan year ends (or for a January 1 plan year, by September 30). The SAR is a narrative summary of the financial information contained in the Form 5500.

Information that should be contained in the SAR include plan funding and insurance information, basic financial information, the rights to additional information, and the offer of assistance in a non-English language. A template of the SAR can be found at 29 CFR Section 2520-104b-10.

Operational Compliance

The plan administrator is obligated to administer the plan in accordance with the plan terms. There is a fiduciary obligation when sponsoring an ERISA plan, which uses the "Prudent Man Rule." Simply stated, the Prudent Man Rule requires that the fiduciaries act in the best interest of the plan participants, and should act as any other prudent person would given similar circumstances. Plan assets can only be used for the benefit of plan participants and beneficiaries to offset certain plan expenses. There are Prohibited Transactions under ERISA; fiduciaries must identify "parties in interest" and transactions with them and ensure that any such transactions are compliant with ERISA.

Plans cannot discriminate among plan participants and beneficiaries. Failure to do so could result in the loss of stop loss coverage for self-funded plans, and could result in an employee complaint, and possible subsequent audit or litigation. In addition, fiduciaries must identify all service providers, determine if they are Business Associates under HIPAA Privacy Rules, and if so, execute a BA Agreement. Service providers must be monitored and audited, as appropriate, and all compensation paid must be reasonable according to standard benchmarks. All contracts should be reviewed to ensure that the plan's interests are protected.

Foreign Language Requirements

Certain documents require foreign language assistance for non-English speaking participants. The SPD requires a notice explaining that assistance is available in the common non-English language. The determination is made based on the employer's workforce, providing notice if the plan covers fewer than 100 participants at the beginning of the plan year and 25% or more are literate in the same non-English language, or the plan covers more than 100 participants at the beginning of the plan year, and the lessor of 500 or 10% or more are literate only in the same non-English language. *The SPD does not have to be translated to that language; only the notice does.*

Assistance must be calculated to provide participants a reasonable opportunity to become informed of their rights and obligations under the plan.

The SBC must be provided in a "culturally and linguistically appropriate manner." SBCs must include a notice within the SBC that a translated version of the SBC is available. Plan sponsors must then provide the translated SBC upon request. In my experience, it's just easier to have the SBC translated at each renewal, and include both English and Spanish in open enrollment packets with a high Hispanic population. In northern California, however, you may need to translate to Chinese or another language, depending on the population in that region. If the plan is self-funded, the plan sponsor is required to translate the SBC.

The determination of the population is based on the population within the *county that the employer is located in; not the employee census.*

The Plan Document does not need to be translated, and no notice is required.

The Affordable Care Act

The Affordable Care Act was signed into law on March 23, 2010.

Continued on page 20

California Agents and Health Insurance Professionals Political Action Committee
2520 Venture Oaks Way, Ste 150
Sacramento, CA 95833
FPPC # 892177

CAHIP PAC CONTRIBUTOR COMMITMENT FORM

Last Name | First Name | Middle

Occupation (Required for FPPC reporting purposes)

Employer (If self employed, name of business; Required for FPPC reporting purposes)

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

City, State, Zip | Phone | Fax

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

City, State, Zip | Phone | Fax

Contact Email Address | Local Chapter

PRECIOUS GEM STONE CONTRIBUTION LEVELS

Levels	Annual	Monthly Minimum	Diamond Levels	Annual	Monthly Minimum
Ruby	$250 - $499	$21/month +	Diamond	$1,000 - $2,499	$84/month +
Emerald	$500 - $719	$42/month +	Double Diamond	$2,500 - $4,999	$209/month +
Sapphire	$720 - $999	$60/month +	Triple Diamond	$5,000+	$417/month +

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

PAYMENT METHOD (attach check or select method below)

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

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

Signed: ______________________ Date: ______________

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


OCAHIP
Orange County
SAVE THE DATE!
CE Day
10 HOURS OF CE! (Between 2 Tracks)
+ Kaiser Permanente Workforce
Wellness and Q4 Carrier Panel (2-hrs)
10 September, 2024
8:30 am to 4:00 pm
Lake Forest Community Center
SPONSORSHIP OPPORTUNITIES AVAILABLE
Register at www ocahu.org


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Providence Medicare Advantage Plans is proud to be a Silver Sponsor of CAHIP-OC. Together, we aim to support and foster collaboration among professionals in the healthcare field along with offering community focused care dedicated to what really matters.
To learn more about Providence Medicare Advantage Plans, contact your local Broker Managers
Michael Corcoran Michael.Corcoran@Providence.org
Pete Pacheco Pete.Pacheco@Providence.org

Legal Briefs, Continued from Page 12

CalSavers has posted FAQs and other resources on its website: **www.calsavers.com**

MUNICIPALITIES: HIGHLIGHTS

San Francisco: Health Care Security Ordinance (HCSO): When calculating the cost of coverage for open enrollment, employers must comply with the HCSO for any San Francisco-based employees (including those who work from home). The HCSO requires "covered employers" (employers with 20 or more workers and non-profit employers with 50 or more workers) to spend a specific amount on a quarterly basis on "health care services" for "covered employees" working in San Francisco 8 or more hours per week:

Employer Size	Number of Workers	2025 Expenditure Rate	2024 Expenditure Rate
Large	All employers with 100+	$3,85/hour payable	$3.51/hour payable
Medium	Businesses w/ 20-99 workers Nonprofits w/50-99 work-	$2.56/hour payable	$2.34/jour payable
Small	Businesses w/ 0-19 workers Nonprofits w/0-49 workers	Exempt	Exempt

Employees who qualify as "managerial, supervisory, or confidential" employees and who also earn at least the following annual or hourly rate for the year are exempt:

Year	Annual Salary	Hourly Salary
2025	$125,405	$60.29
2024	$121,372	$$58.35

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

ERISA's 50th Birthday, Continued from page 17

As a refresher, or for anyone new to benefits, the ACA has requirements for Applicable Large Employers (ALEs) with 50 or more calculated full-time employees beginning in 2016 and must offer coverage to at least 95% of its full-time employees. If the employer is an ALE, they must provide minimum essential coverage that offers minimum value, as defined by the ACA, and meets the affordability provisions of the ACA, or pay a penalty.

Minimum Essential Coverage

Minimum essential coverage is a type of health plan or policy that meets the ACA requirements for medical plans. Failing to meet the MEC coverage would result in a penalty, prior to the removal of such penalty under the Tax Cuts and Jobs Act. Some states, however, including California, have a state penalty similar to the former federal penalty for failure to have coverage meeting the ACA rules. Similar state rules apply in Massachusetts, Jew Jersey, Rhode Island, Vermont, and the District of Columbia.

Full-Time Status

Under the ACA, full-time status and eligibility for coverage is based on 30-hours per week, and to determine if the employer is an Applicable Large Employer (ALE) they must calculate their full-time equivalents. Although only actual full-time employees are eligible for benefits, the FTE calculation is required to determine if the group is considered an ALE and must comply with the ACA rules. Ongoing measurement and tracking is necessary for the FTE calculation.

Minimum Value

The ACA also requires plans to meet Minimum Value provisions of the ACA, meaning that plans must cover at least 60% of the total allowed cost of the plan.

Affordability

Under the ACA, plans must also be "affordable" by ACA standards. Employers can use safe harbors to determine affordability, including

ERISA's 50th Birthday, Continued from Page 20

the W-2 method, the Rate of Pay method, or the Federal Poverty line.

ACA Reporting

The ACA requires ALEs to file forms 1094 and 1095. The complexity of those forms will not be covered in this article due to space limitations. However, I do want to mention that something "new" that has occurred to an "old" requirement is that the Good Faith Penalty Relief for filing incomplete or incorrect forms no longer applies. Employers are required to file the forms correctly now or pay a penalty.

DOL Steps into Cybersecurity Compliance

For an employer sponsoring an ERISA benefit plan, cybersecurity compliance matters because It's the legal standard, it is part of the Plan Administrator's fiduciary responsibility, it's an employer obligation – not an insurer or broker obligation, it's needed and expected to fix problems, be ready to respond to participant inquiries or complaints, as well as be ready in the event of a lawsuit. In addition, compliance matters so that you're prepared in the event of a DOL, IRS, or HHS/OCR audit, prepared in the event of a merger, or wish to be a hero to the CEO/CFO, and if self-funded, it is required to be complaint with stop loss requirements, to name a few reasons.

The DOL released their three sets of Cybersecurity Guidance in April, 2021 for plan fiduciaries, plan sponsors, recordkeepers and plan participants. Why have they released them?

Without sufficient protections, "participants and assets may be at risk from both internal and external cybersecurity threats. ERISA requires plan fiduciaries to take appropriate precautions to mitigate these risks." In addition, "This much-needed guidance emphasizes the importance that plan sponsors and fiduciaries must place on combatting cybercrime and gives important tips to participants and beneficiaries on remaining vigilant against emerging cyber threats."

Summary of Cybersecurity Guidance for Plan Fiduciaries

Tips for Hiring a Service Provider with Strong Cybersecurity Practices

In the first of the 3-part guidance, the DOL focuses on tips for hiring service providers with strong cybersecurity practices. Business owners have a fiduciary responsibility under ERISA to prudently select and monitor service providers. *The guidance makes it clear that each plan sponsor must have a process in place for selecting your service providers.* One question you need to ask them is if their "process" is completely documented? This should be made a part of your RFP process. Then plan sponsors need to find out from the service provider how they

Continued on page 23

Senior Summit 2024 Photos

Top left: Panel Discussion, Room C; Bottom Left: Marketing Panel

Top Right: Michael Fahey, Keynote Speaker; Bottom Right: Medicare Challenges Trophy with Balloons

More Photos Page 32.

Bottom Left: Crowd, Summit Room C; Bottom Right: Panel Discussion, 2025 Medicare Marketing Rules

ERISA's 50th Birthday, Continued from Page 21

monitor their electronic files and data and be sure that every step is completely documented. Plan sponsors/fiduciaries should monitor not only new service providers, but current providers as well.

The service provider or providers should have in place a recognized standard of information security and outside monitoring procedure. Do they have a documented standard of information security that tracks the who, how, why, when for everything they have in their possession? Lastly, plan sponsors should ask who is overseeing the process? Each service provider should assign an individual or team to oversee the process, and the employer/plan sponsor/fiduciary should be asking for details on this procedure (or procedures).

Cybersecurity Program Best Practices

The Guidance calls for a formal, well documented cybersecurity program. According to the DOL, a sound cybersecurity program identifies and assesses internal and external cybersecurity risks that may threaten the confidentiality, integrity or availability of stored nonpublic information. Under the program, the organization fully implements well-documented information security policies, procedures, guidelines and standards to protect the security of the IT infrastructure and data stored on the system.

A "prudently designed" program will protect the infrastructure, information systems and information in the systems from "unauthorized access, use, or other malicious acts by enabling the organization to identify the risks to assets, information and systems; protect each of the necessary assets, data and systems; detect and respond to cybersecurity threats; recover from the event, should one occur; disclose the event as appropriate; restore normal operations and services and quickly and efficiently as possible."

Online Security Tips

The third of the three DOL Guidances provided online security tips. The guidance states that you can reduce the risk of fraud and loss to your retirement account (or other plans), if you follow their (and our) online security tips, including registering, setting up and routinely monitoring your online account, using strong and unique passwords, using multi-factor authentication, keeping personal contact information current, closing or deleting unused accounts, being wary of free wifi, being aware and taking efforts to eliminate or reduce phishing attacks, using antivirus software and keep apps and software current, and knowing how to report identity theft and cybersecurity incidents.

Of course, phishing attacks are aimed to trick you into sharing your passwords, account numbers, and sensitive information, which allow the "bad actors" to gain access to your accounts. You should always be aware of these, and train your staff to be wary of messages that may look like it comes from a trusted organization, to lure you into clicking on a dangerous link or passing along confidential information.

This third set of guidance is an ideal document to provide to plan participants, to encourage them to protect their own electronic data.

Happy Birthday, ERISA!

In closing, I just wanted to once again say "Happy Birthday, ERISA" and thank you for doing what you do to protect plan participants!
##

Author's Note: I'd like to thank Marilyn Monahan of Monahan Law Office for assisting me with my client seminar/webinar preparation and participation, and her assistance with this article. Marilyn can be reached at (310) 989-0993, or at marilyn@monahanlawoffice.com.

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References & Resources:

ERISA Resources:

U.S. Department of Labor, Employee Benefits Security Administration (EBSA):

- *EBSA Website content*
- *Reporting and Disclosure Guide for Employee Benefit Plans*
- *Compliance Assistance Guide:*
- *Health Benefits Coverage under Federal Law, including Self- Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions*
- *Understanding Your Fiduciary Responsibilities under a Group Health Plan*
- *An Employer's Guide to Group Health Continuation Coverage under COBRA, J. Hanley, Deskless Yet Informed, Benefits Quarterly (4th Quarter 2019)*
- *DOL Voluntary Delinquent 5500 filing - DFVCP Fact Sheet at: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/dfvcp.pdf.*

***IRS Resources**: Website materials located at:*

https://www.irs.gov/affordable-care-act

CAA Resources:

***DOL**: Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA):*

https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

***DOL**: Understanding Your Fiduciary Responsibilities under a Group Health Plan:*

https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf

***DOL Cybersecurity Guidance**: https://www.dol.gov/newsroom/releases/ebsa/ebsa20210414*

Disclaimer: The information in this article is not intended to be legal or tax advice of any kind. The author and CAHIP-OC are attempting to provide you with public information to assist the agent and our members. We always advise that you seek the advice of legal counsel as situations vary. ##

CE DAY AGENDA

TIME	CLASS TITLE	LOCATION
8:30 - 9:00 AM	Registration, Continental Breakfast, Visit w/Sponsors	Redwood / Eucalyptus
9:00 - 10:50 AM	▪ Carrier Panel: Addressing Escalating Healthcare Costs and Government Rate Restrictions While Designing Plans that Meet Current Market Demands [2-HR Course: 390931] *Participating Carriers Include: Anthem, Blue Shield of CA, Covered CA Small Business, Health Net, and Kaiser Permanente – Moderated by: Anne Kelly, Kelly and Kelly Insurance Services*	Redwood / Eucalyptus
9:00 - 9:50 AM	▪ Navigating the Covered California Individual Market [1-HR Course: 390930] *Speaker: Adrienne Cariveau*	Maple
10:00 - 10:50 AM	▪ Guarantee Issues and SEP's in CA [1-HR Course: 391021] *Speaker: David Garcia, Warner Pacific*	Maple
10:50 - 11:00 AM	Visit w/Sponsors	Redwood / Eucalyptus
11:00 AM - 12:00 PM	▪ Dental Panel: Understanding and Selling Dental Insurance [1-HR Course: 390999] *Participating Carriers Include: Beam, Colonial Life, Humana, and Principal – Moderated by: Brian Sullivan, BenefitMall* ▪ Tax Write-Offs on Cafeteria Plans vs Income Tax Returns 2024 [1-HR Course: 391000] *Speakers: Anne Kelly, Kelly and Kelly Insurance Services, and Barbara Ciudad, HealthEquity*	Redwood / Eucalyptus Maple
12:15 - 1:10 PM	▪ KEYNOTE PRESENTATION: Addressing Workplace Obesity [1-HR Course: 390897] *Speaker: Dr. Sean Hashmi, Regional Physician Director, Lifestyle and Obesity Medicine, Kaiser Permanente* **Covered CA Small Business – Platinum Keynote Speaker Sponsor*	Redwood / Eucalyptus
1:15 PM - 2:00 PM	Lunch	Redwood / Eucalyptus
2:00 - 2:15 PM	Visit w/Sponsors	Redwood / Eucalyptus
2:15 - 3:05 PM	▪ Revolutionizing Marketing and Content Creation – Harnessing AI Tools for Business Growth [1-HR Course: 390861] *Speaker: Ryan Howard, AnalytIQ Advisors* ▪ Conducting a Compliant Medicare Sales Appointment [1-HR Course: 390965] *Speaker: Michael Roberts, Blue Shield of California*	Redwood / Eucalyptus Maple
3:15 - 4:10 PM	▪ Helping Your Clients Achieve Financial Wellness Simply! [1-HR Course: 390966] *Speaker: John Roberts, TWH Annuity & Insurance Solutions*	Redwood / Eucalyptus
4:15 PM	CE Day Closing	Redwood /Eucalyptus

**Agenda subject to change*

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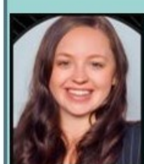

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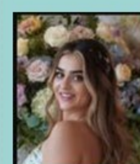

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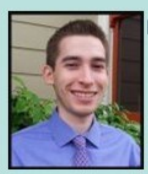

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Mark Your Calendars for CAHIP-OC's Events

CAHIP Orange County

CE Day

Tuesday, September 10, 2024

9am to 5pm

Cybersecurity/Ethics CE

Tuesday, October 8, 2024

Lake Forest Community Center

November Membership Evening/Social Event

November 8, 2024

Holiday Lights Cruise

December 13, 2024

Membership has its "Awards"

NABIP Leading Producers Round Table

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

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

The qualification categories are:

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

Visit NAHU.org go to Membership Resources > LPRT (Leading Producers Roundable) for more information on how you can qualify for this exclusive membership.

MEMBERSHIP NEWS

CAHIP-OC Had Many New Members Join During Senior Summit. Those new members will be highlighted next issue!

Interested in Joining? Many ways to join:

- **Contact our Membership Team:**

Haley Mauser, VP of Membership

Optavise

(707) 628-9260

Haley.Mauser@optavise.com

Agency Memberships Now Available!

Talk to a Board Member

(see page 26 for board roster)

JOIN CAHIP-OC

The 13th Annual Senior Summit Recap 2024

By: Maggie Stedt, C.S.A, LPRT, Summit Co-Chair

This year's Senior Summit was an enormous success with 800 attendees, including individual agents, partners, sponsors, and exhibitors. Every year it keeps getting better and better!! Hosted at the Pechanga Resort and Casino in Temecula, California, it was the place to get way for fun, meet other great agents, carrier and FMO/GA representatives, and acquire comprehensive knowledge and play!

This year's Summit was especially timely in addressing marketing changes, the overhaul of the prescription drug phases and coverages and important legislation in Washington and Sacramento.

We started out on Monday with golf, organized by Juan Lopez with Barbara Ciudad, Ricky Haisha and Ron Chock managing the onsite golf outing. Over 70 golfers enjoyed the challenging Journey golf course at Pechanga and later had fun gathering at the 1882 Cantina for prizes and bragging rights! We heard that there was even a hole in one! While the golfers were out on this challenging course, the rest of the committee were busy with volunteers preparing the badges sponsored by Financial Grade Senior Consultants and registration bags sponsored by Spark FMO. Craig Gussin led the volunteers to help make this a seamless process for the attendees. Meanwhile, Dawn Carroll, Gail James Clarke and George Carson facilitated set up in all areas of the Summit, including general sessions, breakout sessions, stage, sound, catering and arrangements for the Exhibit Hall. Cigna Healthcare provided the social media sponsorship and California Broker was our advertising sponsor.
Tuesday morning the registration booth officially opened with our enthusiastic volunteers and was sponsored by Agent Methods. Aetna Medicare Solutions sponsored the much-in demand coffee, and Primary Care Associates of California sponsored the breakfast on day one. Reverand Marlon Woods started off the program with a warm invocation. The Summit's three executive co-chairs, Maggie Stedt (Orange County), Ricky Haisha (San Diego) and Yolanda Webb (Inland Empire) welcomed everyone to the event. Yolanda recognized our 2024 partners and sponsors for their generous support. The Summit committee also honored Patrick Rodriquez as a founding partner of the Summit and a long time CAHIP-OC member, President, and Founder of Applied General Agency. We paid tribute to our chapter agents that are no longer with us and will always be remembered. We were treated to an inspiring rendition of Lee Greenwood's "Proud to Be an American" beautifully sung by Yasmine Romero, as we honored our attendees that served. Yasmine was followed by "Mindful Morning with Naama - Wellness through Movement" sponsored by Blue Zones Health. Our outstanding Gold Partner, SCAN's own Chief Growth Officer Michael Blea, welcomed our attendees and shared a quick overview of SCAN.

We were honored to have Jessica Brooks-Woods, CEO of the National Association of Benefits and Insurance Professionals (NABIP), share how NABIP continues to represent all agents, brokers and our clients in health and service issues. Jessica shared important wins by NABIP and continuing challenges. Of special note is the introduction of NABIP's Healthcare Bill of Rights that you can share with all your clients. (Go to https://nabip.org/who-we-are/nabip-healthcare-bill-of-rights for more information.)

Our Red Ribbon Legislative Leader, AGA's own Jo Nelson and Jason Bronston, introduced the first panel presentation that addressed the 2025 AEP Marketing Rules. Participants included Austin Felch with Applied General Agency, Dwane McFerrin from Senior Market Sales, Rosamaria Marrujo, president of California Agents and Health Insurance Professionals (CAHIP) and principal of TAIA, Martina Lee Stricklan of Clever Care and Nick Uehlecke from the Todd Strategy Group. Attendees shared that this deep dive into 2025 marketing and compliance issues was one of the most important presentations of the Summit!

After a quick coffee break hosted by Aetna, our first Keynote Speaker, retired Major General Michael Fahey, III, Yolanda

Senior Summit Report, Continued from page 28

Webb and I addressed in conversation how to be an effective leader and how to address leadership challenges. He inspired and challenged the attendees and brought some people to tears as he and Yolanda opened up about their own challenges for the long-term care of their loved ones. Major General Fahey was sponsored by Clever Care as the Keynote Sponsor for day one. The busy morning wrapped up as were treated to an El Indio Fiesta Lunch buffet and attendees were excited to engage with the total of 60 partners, sponsors and exhibitors in the Exhibit Hall that remained open from Tuesday until Thursday at noon.

Our first afternoon session was led by Stanton Sasaki, the head of national broker sales for SCAN, for a review of SCAN's 2025 Benefits. Following a snack break sponsored by MemorialCare Medical Group, the rest of the afternoon was dedicated to informative breakouts, including two CE courses. The CE courses included "The Many Paths to Aged & Disabled Medi-Cal" by Jan Spencley of San Diegans for Healthcare Coverage and "Digital Transformation: Practical Tools for Automating and Growing Your Insurance Business," presented by Elka Soussana of Simpler Horizons Insurance Solutions. Additional breakout sessions were Bryan Willett, FBI Supervisory Special agent presented "Cyber Risk"; Dr. Wayne Dysinger and Kegan Williams presented "Transforming Primary Care: The Blue Zones Initiative"; "The Power of Automation: Innovating Strategies for Your Medicare Business" presented by Sarah Brammer of AgencyBloc; "Understanding Medi-Cal, QMB and LIS" presented by Henry Romero of HRBC.

Wednesday morning breakfast was sponsored by Prospect Medical Systems. The attendees were again welcomed with "Mindful Morning with Naama - Wellness through Movement" sponsored by Blue Zone. The program then turned to legislative issues and concerns both in Washington and Sacramento with two general sessions, "Heard It On the Streets" and a "Legislative Town Hall." Speakers and panelists included Jessica Brooks-Woods, CEO of NABIP, Paul Roberts, CAHIP VP of Legislation, Amanda Brewton, NABIP Medicare Advisory Committee/Medicare Answers Now, and Nick Uehlecke of Todd Strategy Group. The Legislative Town Hall followed, moderated by AGA's Austin Feltch addressing legislative and compliance issues.

After a coffee break sponsored by Green Leaf FMO, the attendees enjoyed a fun time with "Go Wild and Win Big with Medicare Bingo, Medicare's Winning Adventure" brought to Summit by HRBC.

The sit-down lunch sponsored by Senior Market Sales received enthusiastic raves! After lunch, our second Keynote Speaker, Stan Morrison, retired American college basketball coach and athletic director, presented "Living with Truth in Business, Industry, Sports and Life." Stan's insight, delightful stories and warmth were well received! He was sponsored by HRBC Insurance.

As a special guest presenter, Cristina Collazo of CMS, shared a high-level review of the Income Reduction Act of 2022. Our attendees were appreciative of the break-down of information including the explanation of the new Medicare Prescription Payment Plan and identification of the drugs under Medicare's drug negotiations commencing in 2026. She also addressed several pre-submitted questions. We noted that Cristina will be in contact with the Senior Summit Executive Committee regarding additional clarifications of the Creditable Coverage calculations and whether the 2025 new $2,000 drug maximum is calculated on a Maximum Out Of Pocket basis (MOOP) or True Out Of Pocket basis (TrOOP).

Following our snack break sponsored by AltaMed, the next general session was well matched to follow CMS with the Prescription Drug Panel. Moderated by Bill Hepscher of The Canadian Drugstore, the panelists were Amanda Brewton, Nick Uehlecke and Ruby Liu with Alignment. The day finished with a breakout session with Aaron Kassover of Agent Method, "Use Automation to Transform AEP from Absolute Exhaustion Period to Awesomely Easy Peasy." And a second breakout session in which I offered a CE class addressing "Medicare and Group Health Plans" that tackled the Second Payer Rules.

Thursday's American breakfast was sponsored by The Brokerage. The last day of the Summit was all about our carrier partners 2025 First Look and product overviews. First up was Humana (Red Ribbon Partner), followed by Central Health Plan/ Molina HealthCare (Red Ribbon Partner). The morning coffee break was sponsored by Regal, Lakeside and ADOC Medical Groups.

Continued on page 32

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 NABIP PAC?

If so, please complete the form on page 27!

Note: CAHIP PAC contribution form can be found on page 33!

NABIP | pac

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.

Senior Summit Report, Continued from Page 29

We then continued the day with Alignment Health Plan (Red Ribbon Partner) Anthem (Red Ribbon Partner), Aetna Medicare, and UnitedHealthcare. Optum was our sports snack break sponsor. We also want to thank Berwick for being our printed Program partner, Dickerson Insurance Services as our Continuing Education partner, Physicians Mutual as our Decoration partner, Providence as our Awards partner, and Retire with Renewals as the Member Table Sponsor.

The event was closed out with the grand prize presentation by LA Care Health Plan.

Watch for the Summit Attendee Survey with the opportunity for three lucky respondents to receive free registration and a scholarship to our 2025 Senior Summit!

At the time of the writing of this article we have over 27 new members that have joined our NABIP association. Thanks to each of our membership teams from IE, OC, and SD!! A big thank you to Ricky Haisha for all his hard work organizing the presentations and bringing in the best speakers to make this event one of the most informative Senior Summits ever! We could not present such a comprehensive and Medicare focused event without all our partners! A sincere thank you and we appreciate your support and participation!! See you next year!!

Save the date for August 18th to August 21st, 2025 (to be confirmed) to return for the 13th Annual Senior Summit at the Pechanga Resort and Casino. It promises to be even bigger and better than ever! ##

Above: SCAN Presentation

Above: Rosamaria, Jessica, Maggie & Austin; Below: Michael Fahey, Keynote Speaker.

Diversity, Equity, Inclusion & Belonging in the Modern Workplace

Diversity training is designed to facilitate positive intergroup interaction, reduce prejudice and discrimination, and foundationally teach individuals who are different from others how to work together effectively.

Participants of this course will:

- Learn terminology associated with DEI&B
- Obtain a greater understanding of why DEI&B initiatives need to become part of your organizational strategy & structure
- Learn how to identify blind-spots and actionable steps to overcome them

Know how to cultivate a healthy diverse workforce driven by leadership

For more information: ***https://nabip.org/diversity-equity-inclusion-belonging/training***

More Senior Summit Photos on Page 22

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Tax Write-Offs on Cafeteria Plans vs. Income Tax Returns 2024

By: Anne Kelly, Professional Development Committee Member

Navigating the maze of tax regulations can be daunting, especially when it comes to understanding the differences between various tax write-offs. One area that often causes confusion is the distinction between tax write-offs on cafeteria plans and those on income tax returns. For 2024, it's essential to understand how each works to optimize your tax savings.

Understanding Cafeteria Plans

A cafeteria plan, as defined by Section 125 of the Internal Revenue Code, is a benefit plan offered by employers that allows employees to choose from a variety of pre-tax benefits. These benefits might include health insurance, retirement plans, dependent care assistance, and other fringe benefits. The key advantage of a cafeteria plan is the ability to pay for these benefits with pre-tax dollars, which reduces your taxable income.

Key Features of Cafeteria Plans

- **Pre-Tax Contributions**: Contributions to a cafeteria plan are deducted from an employee's gross income before federal and state taxes are calculated, reducing the amount of taxable income.
- **Flexible Spending Accounts (FSAs)**: Many cafeteria plans include FSAs for healthcare and dependent care expenses, allowing employees to set aside pre-tax dollars for eligible expenses.
  - ◊ **Cap on FSAs**: According to the Affordable Care Act (ACA), the maximum amount you can contribute to a healthcare FSA in 2024 is $3,050. This cap is indexed for inflation and may change annually. Dependent care FSAs have a separate cap of $5,000 per year for married couples filing jointly or single parents, and $2,500 for married individuals filing separately.
- **Health Savings Accounts (HSAs)**: Some plans offer HSAs, which combine high-deductible health plans with pre-tax savings for medical expenses.
  - ◊ **HSA Caps for 2024**: The maximum contribution limits for HSAs in 2024 are $3,950 for individuals with self-only coverage and $7,900 for individuals with family coverage. Additionally, individuals aged 55 and older can contribute an extra $1,000 as a catch-up contribution.
- **Dependent Care Write-Offs**: Dependent care assistance under a cafeteria plan allows employees to set aside pre-tax dollars to pay for qualifying dependent care expenses, such as daycare, preschool, and after-school programs. The maximum cap for dependent care FSAs in 2024 is $5,000 per year for married couples filing jointly or single parents, and $2,500 for married individuals filing separately.
- **Qualified Insurance Plan Contributions**: Contributions towards qualified insurance plans, such as health, dental, and vision insurance, can also be made on a pre-tax basis through a cafeteria plan. There is no specific cap on these contributions; however, the plans must comply with IRS regulations and ACA guidelines. Note- FICA Tax (OASDI & Medicare) reduces which has a small effect on social security benefit.

Take into consideration: Uninsured Penalty on California Tax returns verses Employer based **Qualified Medical Insurance Pre-Tax Plan Contributions**

Penalty

You will have to pay a penalty, the Individual Shared Responsibility Penalty, when you file your state tax return if:

- You did not have health coverage
- You were not eligible for an exemption from coverage for any month of the year

The penalty for no coverage is based on:

- The number of people in your household
- Your California state income

Sample penalty amounts for 2023		
Household size	**If you make less than**	**You may pay**
Individual	$49,763	$900
Married Couple	$92,100	$1,800
Family of 4 (2 adults, 2 children)	$142,000	$2,700

The penalty for a dependent child is half of what it would be for an adult, $450, for 2023.

How to estimate

The penalty will be the **higher of** either:

- A flat amount, based on the number of people in the tax household, or
- A percentage of the household income

Flat amount

Pay $900 per adult and $450 per child.

Percentage of household income

Pay 2.5% of the amount of gross income that exceeds the filing threshold requirements based on the tax filing status and number of dependents. California Tax Tables 2024 - Tax Rates and Thresholds in California (icalculator.com)

Tax Write-Offs on Income Tax Returns

In contrast to cafeteria plans, tax write-offs on income tax returns are deductions or credits that taxpayers can claim to reduce their taxable income or tax liability. These write-offs are available to all taxpayers, regardless of whether they participate in a cafeteria plan.

Common Income Tax Write-Offs

- **Standard Deduction**: For 2024, the standard deduction amounts have increased, providing a baseline reduction of taxable income for all taxpayers.
- **Itemized Deductions**: Taxpayers can choose to itemize deductions, which might include medical expenses, mortgage interest, charitable contributions, and state and local taxes.
- **Retirement Contributions**: Contributions to traditional IRAs and 401(k) plans are deductible, reducing taxable income.

Tax Write-Offs On Cafeteria Plans vs Income Tax Returns 2024, Continued from page 32

- **Retirement Contribution Caps for 2024**: The contribution limit for 401(k) plans in 2024 is $23,000. For individuals aged 50 and over, the catch-up contribution limit is $7,500, bringing the total to $30,500. For traditional and Roth IRAs, the contribution limit is $7,000, with an additional $1,000 catch-up contribution for those aged 50 and over, totaling $8,000.
- **Education Expenses**: Certain education-related expenses, such as tuition and student loan interest, can be deducted or credited. Guide to Tax Filing Benefits for College Students | H&R Block® (hrblock.com)
- **Credits**: Tax credits like the Earned Income Tax Credit (EITC), Child Tax Credit, and education credits directly reduce tax liability.
- **Dependent Care Write-Offs**: The Dependent Care Tax Credit (DCTC) is a non-refundable credit that allows taxpayers to claim a percentage of qualifying dependent care expenses. For 2024, the maximum amount of expenses you can claim is $3,000 for one qualifying individual or $6,000 for two or more qualifying individuals. The credit percentage varies based on your income, with a maximum credit rate of 35% for lower-income taxpayers and a minimum of 20% for higher-income taxpayers.

Qualified Insurance Plan Contributions
Contributions towards qualified insurance plans, such as health, dental, and vision insurance, can also be written off on your income taxes:

- **Above-the-Line Deduction**: Self-employed individuals can deduct health insurance premiums for themselves, their spouses, and dependents directly from their gross income, reducing their AGI. (Your adjusted gross income (AGI) is your total (gross) income from all sources minus certain adjustments such as educator expenses, student loan interest, alimony payments and retirement contributions.)
- **Itemized Deduction**: Employees can include their insurance premiums in their itemized deductions if they **exceed 7.5% of their AGI**. This is less beneficial compared to the pre-tax benefit through a cafeteria plan.

Federal and California State Tax Thresholds for 2024
California Tax Tables 2024 - Tax Rates and Thresholds in California (icalculator.com)
Understanding the tax brackets and thresholds is crucial for effective tax planning.

Federal Tax Brackets for 2024

- **Single Filers**:
  10% on income up to $11,000
  12% on income over $11,000 up to $44,725
  22% on income over $44,725 up to $95,375
  24% on income over $95,375 up to $182,100
  32% on income over $182,100 up to $231,250
  35% on income over $231,250 up to $578,125
  37% on income over $578,125

  Married Filing Jointly:
  10% on income up to $22,000
  12% on income over $22,000 up to $89,450
  22% on income over $89,450 up to $190,750
  24% on income over $190,750 up to $364,200
  32% on income over $364,200 up to $462,500
  35% on income over $462,500 up to $693,750
  37% on income over $693,750

California State Tax Brackets for 2024

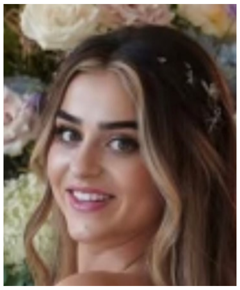
- **Single Filers**:
  1% on income up to $10,099
  2% on income over $10,099 up to $23,942
  4% on income over $23,942 up to $37,788
  6% on income over $37,788 up to $52,453
  8% on income over $52,453 up to $66,295
  9.3% on income over $66,295 up to $338,639
  10.3% on income over $338,639 up to $406,364
  11.3% on income over $406,364 up to $677,275
  12.3% on income over $677,275
  Additional 1% surcharge on income over $1,000,000 (Mental Health Services Tax)
- **Married Filing Jointly**:
  1% on income up to $20,198
  2% on income over $20,198 up to $47,884
  4% on income over $47,884 up to $75,576
  6% on income over $75,576 up to $104,906
  8% on income over $104,906 up to $132,590
  9.3% on income over $132,590 up to $677,278
  10.3% on income over $677,278 up to $812,728
  11.3% on income over $812,728 up to $1,354,550
  12.3% on income over $1,354,550
  Additional 1% surcharge on income over $2,000,000 (Mental Health Services Tax)

Comparing Cafeteria Plan Write-Offs and Income Tax Write-Offs
While both cafeteria plan write-offs and income tax return write-offs offer tax savings, they operate differently:

- **Timing and Application**: Cafeteria plan write-offs reduce taxable income at the payroll level, before taxes are withheld. Income tax return write-offs are claimed when filing annual tax returns, either reducing taxable income (deductions) or directly reducing tax owed (credits).
- **Eligibility**: Cafeteria plans are employer-sponsored, meaning only employees of participating employers can benefit. Income tax return write-offs are available to all taxpayers, regardless of employment status.
- **Types of Savings**: Cafeteria plans primarily offer savings on payroll taxes (federal, state, and sometimes Social Security and Medicare taxes). Income tax return write-offs can affect a broader range of taxes, including federal, state, and local income taxes.

Maximizing Tax Savings
To maximize tax savings in 2024, consider leveraging both Employer Based Tax Savings plans as well as Maximizing Income Tax write-offs.
##

Editor's Note: Anne Kelly can be reached at: anne@kellyandkellyinsurance.com



The Hidden Costs: How Ultra-Processed Foods Affect Health and Insurance

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

Ultra-processed foods (UPFs) have become a staple in the modern diet, characterized by their convenience, palatability, and extended shelf life. However, the health implications of consuming these foods are increasingly recognized as detrimental, with copious amounts of studies linking them to a range of chronic diseases.

We often think processed foods are readily easy to spot on our local grocery run. From your common bag of Lays chips to the tub of organic Greek yogurt sitting in your fridge, 'virtually all foods sold in stores can be classified as processed to some degree' (emetabolic). According to the Metabolic Research Center, most foods deteriorate and lose nutrients immediately after harvest. Still, a few straightforward processing steps can enhance these products. The act of processing food involves altering its natural state to achieve various objectives, including extending shelf life, ensuring the food's safety, enhancing flavor, or even boosting nutritional value. Common food processing methods include pasteurizing, canning, fermenting, freezing, and drying. The key difference between processed and ultra-processed foods is that UPFs are extensively modified and contain high levels of unhealthy fats, refined sugars, and sodium. UPFs also undergo industrial processes, like hydrogenation, and contain additives like 'dyes, stabilizers, flavor enhancers, emulsifiers, and defoaming agents' (Cambridge University Press). While basic processing can enhance food safety and nutrition, distinguishing between minimally processed foods and ultra-processed foods is crucial for making healthier choices.

Health Issues Linked to Ultra-Processed Foods

Obesity: UPFs are notorious for their high energy density coupled with a lack of essential nutrients, which can lead to excessive caloric intake and weight gain. This dietary concern is underscored by data from the Centers for Disease Control and Prevention (CDC), which reveals that over 42% of American adults are now classified as obese—a sharp increase from figures recorded in previous decades.

Metabolic Syndrome: Metabolic syndrome encompasses a cluster of conditions, including hypertension, high blood sugar, excess body fat around the waist, and abnormal cholesterol levels.

Cancer: Research indicates a link between UPFs and certain types of cancer. A study published in the British Medical Journal found that a 10% increase in the proportion of UPFs in the diet was associated with a 12% increase in the risk of cancer.

Inflammatory Diseases: Heart disease and congestive heart failure are significantly influenced by diet. UPFs, rich in trans fats, sugar, and sodium, are known to cause chronic inflammation, a key factor in the development of cardiovascular diseases. The American Heart Association states that nearly half of all U.S. adults have some form of cardiovascular disease, costing the healthcare system over $351 billion annually.

Sodium and Hypertension: UPFs are notoriously high in sodium, creating a major risk factor for hypertension (high blood pressure). Excessive sodium intake can lead to fluid retention, increasing blood volume and, subsequently, blood pressure.

Mental Health Issues Linked to Ultra-Processed Foods

Depression and Anxiety: Several studies have found a correlation between high UPF consumption and increased rates of depression and anxiety. A study published in Public Health Nutrition found that individuals who consumed more UPFs had a higher risk of developing depression. Currently, about 20% of Americans suffer from depression, exceeding the world average (NSDUH).

ADHD: There is growing evidence that diet plays a role in attention deficit hyperactivity disorder (ADHD). UPFs, with their high sugar content and artificial additives, have been implicated in exacerbating ADHD symptoms.

Alzheimer's and Dementia: Emerging research suggests that a diet high in UPFs may increase the risk of neurodegenerative diseases such as Alzheimer's and dementia. According to the Alzheimer's Association, Alzheimer's and other dementias cost the U.S. healthcare system $305 billion annually, a number expected to rise as the population ages.

The Economic Impact

The economic burden of diet-related diseases is immense. The American Public Health Association estimates that obesity alone costs the U.S. healthcare system approximately $147 billion annually. When factoring in the costs associated with diabetes, cardiovascular diseases, and mental health disorders, the total economic impact of ultra-processed food (UPF) consumption is substantial. These costs are shouldered not only by the healthcare system, but also by individuals, families, and society at large. In recent discussions with Kaiser Permanente's Workforce Wellness team, we have proposed aligning our efforts to transform American dietary habits. As key marketing agents, we serve as the crucial link between carriers and clients, explaining benefits and facilitating access to care. With a renewed emphasis on wellness within our industry, the Professional Development Team - OC advocates for a concerted effort to combat the detrimental effects of UPFs. We propose launching an initiative to educate members about the severe health impacts of UPFs and the

Continued on page 37

Hidden Costs, Continued from Page 36

consequent rise in healthcare premiums.

Mission for Change: Awareness, Education, and Policy

Awareness: Public awareness campaigns are crucial in educating people about the dangers of UPFs. Initiatives such as clear labeling, informative advertising, and public service announcements can help consumers make healthier choices.

Education: Integrating nutrition education into school curriculums and community programs can empower individuals to make informed dietary decisions.

Public Policy: Policy changes are essential to create an environment that supports healthy eating. This can include implementing taxes on sugary drinks, subsidizing fruits and vegetables, and regulating the marketing of UPFs, especially to our youth.

The health and mental repercussions of ultra-processed foods are both profound and alarming. The spectrum of associated issues, ranging from obesity and metabolic syndrome to cancer and mental health disorders, underscores the detrimental impact of these foods on our overall well-being. By fostering awareness, advancing education, and implementing supportive policies, we have the opportunity to transform American dietary habits and enhance health outcomes.

We are pleased to announce a distinguished roster of speakers for both CE Day and the February Sales Symposium, who will offer insights that resonate with our perspective. Dr. Sean Hashmi, Regional Physician Director of Lifestyle and Obesity Medicine at Kaiser Permanente, will address the issue of workforce obesity at both events. Furthermore, Dr. Robert Lustwig will deliver the keynote address at the February Sales Symposium, where he will explore whether obesity and metabolic syndrome should be regarded as primary issues of private or public policy.

What You Can Do!

It is imperative that we, as advocates, actively combat these challenges to protect our communities. Without confronting this critical problem head-on, we risk perpetuating escalating healthcare costs and failing to achieve meaningful improvements in public health.

We suggest that health insurance carriers do their part by educating and advertising against UPFs. Mechanisms such as simple banners or handouts at your upcoming Open Enrollment meetings would go a long way toward igniting a grassroots movement. We hope this movement will gain momentum, advocate for a complete change in our eating habits, and ultimately reverse years of rising healthcare costs associated with chronic illnesses and mental health issues linked to ultra-processed foods.

We are looking to create purchasable 'Open Enrollment Banners' carrying these messages- Please contact a member of the CAHIP Professional Development team for more information. ##

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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!

October 8, 2024

Cybersecurity & Ethics CE Panel with Adriana Mendieta and Miguel Villegas

November 8, 2024

November Membership Evening Event

December 13, 2024

Holiday Lights Cruise Event

Mark Your Calendars Now!

www.ocahu.org 714-441-8951, x3 orangecountyahu@yahoo.com

And, Mark Your Calendars for our November and December Special Events!

November 8 Evening Event

December 13 Holiday Lights Cruise

NAHU Professional Development

Are you new to the industry? Do you want to brush up on new concepts? Do you have employees who need training? Do you want to be an expert on industry topics so you can educate your clients?

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NAHU has an Online Learning Institute and offers courses in a variety of areas that can help you be successful. NAHU members receive a discount on enrollment of up 30%. Some of the course work and certificates are listed below, but there are many more options on the website. For more information on courses and enrollment, visit the NAHU website at http://nahu.org/professional-development/courses.

- Registered Employee Benefits Consultant (REBC) Designation
- Single-Payer Healthcare Certification
- Account-Based Health Plans Certification
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- Health Insurance 101
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- 15 -

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Mark Your Calendars for This

Cannot Miss Event!

Cyber Risk Cybersecurity & Insurance Ethics

CE Course 390236

October 8, 2024

Lake Forest Community Center

Don't Forget to Register...

CAHIP-OC CE Day

Tuesday, September 10, 2024

Lake Forest Community Center

Details can be found on pages 24 & 25

Register at: *www.ocahu.org*

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NABIP

Shaping the *future* of healthcare

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

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CYBERSECURITY ETHICS CE PANEL—OCTOBER 8, 2024, LAKE FOREST COMMUNITY CENTER

MEMBERSHIP EVENING EVENT—NOVEMBER 8, 2024

HOLIDAY LIGHTS CRUISE EVENT—DECEMBER 13, 2024

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