Volume 20, Issue 3 Nov/Dec 2025

NABIP
2025 Gold Certified

COIN

County of Orange Insurance News

NABIP
2024 Pacesetter Award

Last Minute Tips & Tricks For The Final Weeks of 4th Quarter

Also inside this issue

- *Where are The Young People?*
- *Compliance Corner*
- *Senior Summit Wrap-Up*
- *Changes in Group Insurance Creditable Coverage Creates an Issue for Aged Workers*
- *Pizza Party & Holiday Cruise*
- *Membership – When You Know, You Know!*
- *And Much More!*

CAHIP
Orange County

Health Net is proud to support CAHIP-OC

Health Net has Simplified Underwriting Programs, including our Enhanced Choice Promotion:

5 Enrolled Subscribers Minimum

- Groups of 5-100 eligible employees
- 25% participation is required - Employees enrolled on another ACA carrier through the same employer are valid waivers and will not count against the 25% participation!

Highlights

- Mix and Match all of HMO networks alongside our Full PPO network including Cigna for out of state employees
- No DE9C, payroll, or ownership documents are required
- No prior carrier bill is required
- Wrap Friendly! Health Net can be written alongside any carrier, no limit to the number of carriers if participation is met
- There must be enough valid waivers listed on the census to verify that the group meets participation

Contact your Account Executive

Ask about our new PPO Unlimited dental plans that launched in 2025 — available with no waiting periods! Pair alongside our PPO Medical plans, and our HMO plans—HMOs with zero medical deductibles! Enjoy the flexibility of our underwriting, the ability to mix and match all plans and all networks! One Health Net invoice: medical, dental, vision!

Leticia M. Ruiz
Account Executive
San Diego, South OC, Imperial
leticia.m.ruiz@healthnet.com
(619) 756-5345

Ramon Duran
Account Executive
North OC, South Bay LA
ramon.duran@healthnet.com
(949) 796-5845

health net™

TABLE OF CONTENTS

Thank you for being a part of CAHIP-OC!

What's Inside

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
PRESIDENT'S MESSAGE
By: Sarah Knapp, CAHIP-OC President

Dear CAHIP OC Members,

As we approach the end of 2025, I want to extend my heartfelt thanks to each of you for your unwavering support and dedication to our association. Your involvement is what continues to make CAHIP Orange County a vibrant, collaborative, and impactful community.

We have some exciting events planned to close out the year, and we hope you'll join us as we celebrate all that we've accomplished together:

November brings a fun and relaxed **Member Appreciation Pizza Party & Happy Hour**, generously hosted by **Engage PEO and Colonial Life**. This 4th quarter gathering is a perfect opportunity to unwind, reconnect, and enjoy the company of your fellow members in a casual setting.

In **December**, we're thrilled to once again host our annual **Holiday Harbor Cruise**—a festive evening of connection, celebration, and stunning views of the yachts and coastal homes beautifully decorated with millions of holiday lights, as we wrap up the final quarter of the year.

We hope you'll be able to join us for these fun and meaningful opportunities to connect before the year comes to a close.

Wishing you a magical holiday season filled with joy, laughter, and time spent with family and friends.

Warm regards,

Sarah Knapp, CAHIP-OC President

CAHIP-OC October, 2025 In –Person Meeting

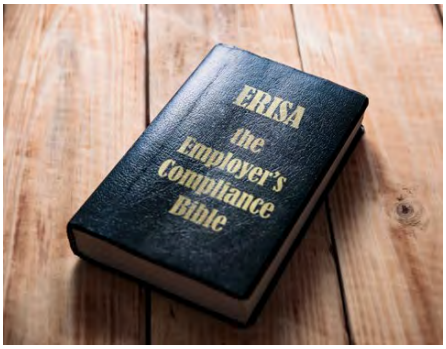
(more photos on pages 11 and 15)

Feature Article: Last Minute Tips & Tricks During The Final Weeks; Reminders of Required Disclosures and Hints for a More Compliant Open Enrollment Season

By: Dorothy Cociu, CAHIP-OC VP of Communications & Public Affairs & President of Advanced Benefit Consulting & Insurance Services, Inc.

As we're winding down to the last 2 months of the 4th quarter, the stress level for most agents is through the roof… Too much to do, too little time, and fears of not doing everything they can for their clients and plan participants during open enrollment. I thought a few "Tips & Tricks" may help you all survive as we push through the final weeks of the 4th quarter.

As we all know, organization and keeping a cool head are necessary during these final weeks. I asked my friend Anne Kelly of Kelly & Kelly and Patrick & Patrick Insurance Services, now that we're in the middle of Open Enrollment/4th Quarter, what are a few things you do as an agent to stay organized and ready for your clients' requests? Anne responded, "It's important to check that you have an accurate census as well as the plans employees are currently on. When shopping renewals, it's always a good idea when looking at changing carriers to verify that everyone's current doctors are in the networks you are proposing." Anne continued, "You can also get caught out if an employee is on any expensive RX, so always a good idea if time allows it to at least ask employees to let you know if they are taking any expensive medications." Of course, I'd caution that if/when you do so, that you do this in a private area, to be sure you're not violating HIPAA Privacy rules and patient protections. Some employer clients may require you to also have a written HIPAA Authorization to have such conversations with plan participants.



Part of that organization is also plan compliance, and knowing what you should be doing to assist your clients. I thought it would be helpful to remind you all of the required disclosures to include in your open enrollment materials, as well as provide some helpful suggestions on new legislation that could impact your employer plan sponsor clients. I asked ERISA/Benefits Attorney, Marilyn Monahan, why it is so important to double-check that agents are including the necessary disclosures in open enrollment materials? "It is always important to make certain employers satisfy all the applicable legal requirements," Marilyn stated. "Doing so will also provide peace of mind down the road—for example, in the event the employer is later audited. But it is also important to remember that the disclosure requirements are really all about communication: ensuring that participants and beneficiaries understand the terms of the plan, and their rights and responsibilities under the plan."

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. I thought it would be a helpful thing to just remind everyone of the ERISA and other requirements for plan sponsors, many of which are required at Open Enrollment.

I asked Marilyn what she thinks is the most forgotten or skipped over requirement that plan sponsors aren't doing or their agents aren't necessarily reminding them of during open enrollment? "Many employers do not have a plan document. Although the plan document does not have to be distributed at open enrollment, employers must have one," replied Marilyn. "With regard to distributions made during open enrollment, I would say that too many employers do not appreciate the need for a wrap document, and therefore do not have a wrap document to distribute. The wrap document contains essential terms—such as eligibility requirements and waiting periods—and those terms must be reduced to writing and distributed to participants."

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). This may be a review for many of you, but I thought it was an important time to remind everyone of the requirements.

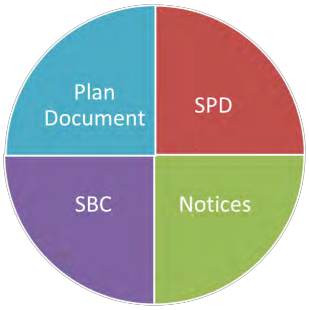
Plan Document

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.

Continued on page 6

Tips & Tricks During Open Enrollment, Continued from page 5

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 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

Tips & Tricks During Open Enrollment, Continued From Page 6

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.

It's important to be aware that SBC requirements have recently been modified/updated for 2025. I asked Marilyn if she could tell our readers, in general, what was included or changed in the SBC rules, and what date the new SBCs are effective? "From the beginning, plans have been required to include taglines in up to 4 different languages, advising participants and beneficiaries that they can seek assistance in those languages," stated Marilyn. "They can also request an SBC translated into those languages. As of the first day of the 2025 plan year, the list of languages has been expanded to 8. The revised SBCs reflect this change."

It's important to note that many SBCs may have already been prepared or distributed prior to the release of the new requirements for SBCs for plan year 2025. If that is the case, particularly if the employer plan sponsor is self-funded, you must modify the SBC for the 2025 plan year as soon as possible, and redistribute to plan participants, to stay in compliance. Hopefully most carriers did the same, but be advised, they may have only notified the agents or plan sponsors (if they notified them at all) by way of an email with a link to their website for the latest SBC, so it's important to follow-up with the carriers and download the most up-to-date SBCs for your clients, and ask them to redistribute and have available.

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 SBC in 2025 are $1,443 per failure (i.e. each plan participant that was supposed to receive an SBC is a separate violation/penalty, so this can be very costly for employers).

Amendments to the Plan

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 you should ***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 (note that rules changed last year and fewer plans are now considered creditable coverage, so those employers should distribute the Non-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.

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-

Continued on Page 8

Tips & Tricks During Open Enrollment, Continued From Page 7

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 timeframe 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

A lot of employers have moved to or are planning to move toward digital platforms for their benefits. I asked Marilyn Monahan to remind us what is most important for agents and plan sponsors to know regarding the use of electronic notices, and who (job positions, types of employees, etc.) may or may not qualify for using those? "Electronic enrollment and distribution platforms can be very effective, and are often preferred by both employees and employers," stated Marilyn. "However, employers must still follow the ERISA electronic distribution rules. Those rules—which were issued in 2002—are not very up-to-date, but they are still applicable. For employees who do not use the employer's electronic information system on a daily basis, the employer must obtain consent before it can rely on electronic distribution."

The electronic distribution rules were, as Marilyn stated, 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 copy of all materials upon request, at no charge to the employee or plan participant.

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.*

Continued on Page 9

Tips & Tricks During Open Enrollment, Continued From Page 8

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

The Affordable Care Act

Prior to writing this article, I asked Anne Kelly what the most common compliance questions her clients are asking of her this OE season? "ACA Compliance," Anne responded. "For employers with over 50 FTEs [it] is always an issue at renewal. If the renewal is Off Calendar year and they are still in small group - age rated market, you should always compile an ACA rate check sheet for 2024 as well as 2025 using the respective measure. Make sure the employer is setting their [participant] contribution at a level that assures the lowest cost plan offered meets ACA for [the] majority of employees (the Law requires 95% of employees are offered an affordable min value plan)."

As a matter of review, I thought it might be helpful to review the basics of ACA compliance this renewal season.

The Affordable Care Act was signed into law on March 23, 2010. In 2025, we're celebrating the 15th anniversary of the ACA.

One of the fears and concerns this open enrollment related to ACA compliance is affordability. When I asked Anne Kelly about this, she stated that her clients are very much concerned with meeting the ACA Affordability Mandate. Anne stated that "it is becoming increasingly difficult as rates have become unaffordable for both employers and employees." Keep in mind, there is a difference between the government-mandated affordability and what is actually affordable to the employee/plan participants.

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 or state 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 at least Massachusetts, New 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 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

Continued on Page 10

Tips & Tricks During Open Enrollment, Continued From Page 9

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*
- *Cybersecurity Program Best Practices*
- *Online Security Tips*

The third of the three DOL Guidances provided is 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 (online security tips) is an ideal document to provide to plan participants, to encourage them to protect their own electronic data. Although not absolutely required, I highly recommend these be distributed during each Open Enrollment period.

Other Compliance Items Employer Plan Sponsors Are Asking About This Open Enrollment Season

Other important compliance items to keep in mind this open enrollment season are COBRA compliance, HSA/FSA rules and the impacts of the One Big Beautiful Bill.

Anne stated as a reminder that you should "Check the group Size against COBRA requirements, and checking if they are CALCOBRA under 20 employees, or have they outgrown CalCOBRA and are now the employer's responsibility?" Anne continued, "If Federal COBRA, think about using a TPA to handle COBRA and make sure the employer knows there are fees involved." Keep in mind also, with the scheduled end to the Premium Tax Credits in the Exchanges, fewer people are likely to enroll in the individual marketplaces (since the PTC is scheduled to end on December 31, 2025, unless an extension is granted prior to this). This, and the new requirements for Medicaid and MediCal are the major issues in the current federal government shutdown. With fewer qualifying for PTCs, more employees and dependents may be enrolling in group health plans, and more may be continuing on COBRA or CalCOBRA in 2026.

Other compliance concerns this season include the OBBB provisions that affect benefits.

OBBB Provisions Applicable at Open Enrollment

I detailed this in the September/October issue of the COIN in my feature article on the One Big Beautiful Bill, but as a reminder, some of these provisions should spark at least a conversation with your clients during this open enrollment season. Anne Kelly suggested you "Check Limits on H.S.As as well as F.S.A plans, making sure limits and any corresponding plan docs are updated. The OBBB increased limits, and if employers are increasing limits them, their plan docs should be reviewed and updated." Thanks, Anne, for paying attention to my article, as well as the October 7, 2025 CAHIP-OC in person discussion on this topic, presented by myself and Marilyn Monahan!

Due to the OBBB, there are changes coming for Medicaid (Medi-Cal in California) and the ACA Marketplace. I asked Marilyn to remind us of what she thinks are the most important things agents should be discussing with their employer clients during this open enrollment period about these changes? "In the short term," Marilyn replied, "there are several changes to benefit plans that employers may want to implement—although they do not have to. For example, they may want to adjust their HDHPs to address the new rules on telehealth and direct primary care. Or, employers may want to consider increasing the amount employees may contribute to the DCAP. Any changes that are made, should be communicated to employees so that they appreciate the new benefits that may be available to them. In the long term, employers need to realize that premium costs will probably increase in the next few years, and so they should be thinking about any changes they may want to consider in the design of their plans to help prepare for these cost increases."

I suggest you go back and read the Feature Article in the September-October, 2025 issue of the COIN for more information.

Conclusion

As we all make that final push in the 4th quarter of 2025, it's important that you check the plan compliance of your clients, answer the questions they have, and most importantly, find time to take care of yourselves and families. A few happy hour gatherings and celebrations aren't a bad idea either! To help with this, we have a couple of fun events scheduled, including the CAHIP-OC Pizza Party November 12, from 5:30 to 7 pm at Sgt Pepperoni's in Irvine. This is a great way to destress and take a breather from the busy season! (see ad on page 16), We also have the ever-popular Holiday Cruise on December 9 (ad [age 18), so please register and enjoy! ##

Join CAHIP-OC For Their Upcoming Events!

Save the Date!

CAHIP-OC Annual Sales Symposium

March 10, 2026

8 am to 4 pm

More Photos From the Oct. 7, 2025 One Big Beautiful Bill In-Person Meeting, Featuring Speakers Dorothy Cociu & Marilyn Monahan

Register Now!

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 updates of interest to benefit professionals, at the federal and state levels:

FEDERAL: UPDATES

2026 Health and Welfare Benefit Plan Limits: The Internal Revenue Service (IRS) has announced some plan and contribution limits for 2026. The list below also contains updates created by the One Big Beautiful Bill (OBBB):

- Health Flexible Spending Account (FSA): $3,400
- Health FSA Carryover: $680
- Dependent Care Spending Account: $7,500
- Fringe Benefit: Qualified Transportation Expenses: $340
- Fringe Benefit: Qualified Parking Expenses: $340
- Educational Assistance Program: $5,250
- Adoption Assistance Program: $17,670
- Qualified Small Employer Health Reimbursement Arrangement (QSEHRA): $6,450 ($13,100 for family coverage)

Summaries of Benefits and Coverage (SBCs): On September 29, 2025—with no fanfare—the Centers for Medicare and Medicaid Services (CMS) issued new and revised "summary of benefits and coverage" (SBC) templates. What changes were made?

- The revised English language templates include taglines in 8 languages (Spanish, Traditional Chinese, Tagalog, Navajo, Pennsylvania Dutch, Samoan, Carolinian, and Chamorro), rather than the 4 languages that had been included in earlier versions of the SBCs (Spanish, Chinese, Tagalog, and Navajo).
- CMS also posted templates in the 4 new languages (Pennsylvania Dutch, Samoan, Carolinian, and Chamorro).

According to CMS, "There are no other substantive changes to the content of any of the documents."

Although CMS did not issue these revised templates until

Continued on page 13

HIPAA/HHS/OCR Updates

Just a couple of updates on HIPAA Privacy & Security Enforcements. First, on September 9, 2025, **HHS Releasesd an Updated Security Risk Assessment Tool**

The U.S. Department of Health and Human Services Office for Civil Rights (OCR) and the Assistant Secretary for Technology Policy (ASTP) announced the release of version 3.6 of the Security Risk Assessment (SRA) Tool.

To help th public make the most of these updates, ASTP and OCR are hosted live webinars on September 15 and September 16. Experts demonstrated new features, walk through reports, and answer your questions.

Version 3.6 includes important updates to support your HIPAA risk assessment process:

- **New reviewed-by confirmation button** to record approvals and dates for audit tracking
- **Updated NIST-aligned risk scale**, changing "medium" to "moderate"
- **Enhanced reports** with section-specific details and updated disclaimers
- **Refreshed library files** to mitigate vulnerabilities in outdated components

Improved content for questions, responses, and education
Download SRA Tool v3.6 →

Register for a Webinar →

Follow HHS OCR on X (formerly Twitter) at @HHSOCR.

For additional information on a wide range of topics about the HIPAA Rules, please visit https://www.hhs.gov/hipaa/index.html. Information about OCR's civil rights authorities and responsibilities can be found at https://www.hhs.gov/civil-rights/index.html. If you believe that a HIPAA-covered entity or its business associate violated your (or someone else's)

Continued on page 27

Legal Briefs, Continued from page 12

last month, plans—including both fully insured and self-funded plans—should be using revised SBCs with the expanded list of taglines starting with plan years beginning on or after **January 1, 2025**.

The SBC templates can be found at this link: Other Resources | CMS

Gag Clause Prohibition Compliance Attestation (GCPCA): The mandate to remove gag clauses from contracts with networks, and then attest to the government that you have done so, was added by the Consolidated Appropriations Act, 2021 (CAA). Attestations must be made annually, on or before **December 31**. Whether your plan is fully insured or self-funded, large or small, you must comply. If the employer's plan is fully insured and the carrier attests—the employer should have written confirmation from the carrier—the employer does not have to attest. If the carrier does not attest, or the plan is self-funded, the employer is responsible for the attestation. Please refer to the July/August C.O.I.N. for more information.

FAQs about Affordable Care Act Implementation Part 72: On October 16, 2025, the Departments of Health and Human Services, Labor, and Treasury (the "Departments") issued another set of FAQs pertaining to ACA implementation. This set of FAQs focuses on fertility benefits.

Under existing law, the Departments have identified 4 categories of "excepted benefits." Excepted benefits do not have to comply with certain provisions of the law otherwise applicable to group health plans. The FAQs clarify "existing categories of excepted benefits employers can use to offer fertility benefits."

First, under the new guidance, employers may offer fertility benefits as an "independent, noncoordinated excepted benefit," if applicable conditions are met. This option may not be self-funded. The FAQs also specify that enrollment in such an excepted benefit would not prohibit contributions to a health savings account (HSA).

Second, fertility benefits may be offered through an excepted benefit health reimbursement arrangement (HRA)—so long as the 2019 regulations governing excepted benefit HRAs is followed. This arrangement could be used to reimburse an employee's out-of-pocket costs with respect to fertility benefits. The FAQs also explain that an employer may offer benefits for coaching and navigator services to help employees and their dependents understand their fertility options under an employer assistance program (EAP) that qualifies as a limited excepted benefit.

The FAQs state that more guidance may be issued in the future relating to ways in which employers may offer fertility benefits.

CALIFORNIA: HIGHLIGHTS

The 2025 legislative year is at an end. Governor Newsom had until October 12th to sign or veto all bills presented to him by the legislature this year. Bills signed by the governor will take effect January 1, 2026, unless by they have an earlier or later effective date. We summarize below some of the 2025 bills of interest to benefit professionals. But first, we start with brief summaries of some 2024 legislation that had delayed effective dates.

2024 Legislation

S.B. 729 – Treatment for Infertility and Fertility Services: Governor Newsom signed this bill in 2024, but the effective date of the bill was delayed. The terms of the bill apply to insurance policies and heath care service plan contracts that are issued, amended, or renewed on or after **January 1, 2026.** As a result of this bill, large group plans must cover the diagnosis and treatment of infertility and fertility services (including IVF); for small group plans, insurers/HMOs must offer the option to employers. There is an exemption for religious employers, and the law does not apply to plans/policies issued to PERS until July 2027.

A.B. 2843 - Rape and Sexual Assault: Under this 2024 bill, insurers/HMOs must cover emergency and follow-up care for a participant treated for rape or sexual assault for the first 9 months after treatment is initiated, without imposing cost sharing. For the purposes of this law, "follow-up health care treatment" includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

Plans/policies cannot, as a condition of providing coverage, require (1) the filing of a police report, (2) that charges to be brought against an assailant, (3) or that an assailant be convicted of rape or sexual assault. This provision applies to insurance policies and health care service plan contracts issued, amended, or renewed on or after **July 1, 2025**.

S.B. 1180 – Emergency Medical Services: S.B. 1180 requires insurers/HMOs to provide coverage for emergency services provided by a community paramedicine program, mobile integrated health program, and triage to alternate

Continued on page 14

Legal Briefs, Continued from Page 13

destination program. These programs may be offered by fire departments, but may not be covered by insurance. This mandate applies to insurance policies and health care service plan contracts issued, amended, or renewed on or after **July 1, 2025**.

A.B. 3275 – Claim Reimbursement: A.B. 3275 changes the rules on the amount of time insurers/HMOs have to process claims. Under the new rules, claims will have to be paid within 30 calendar days (not working days). These changes go into effect **January 1, 2026**. If claims are paid late, the insurer/HMO must add 15% interest and, if they do not, they will owe the greater of an additional $15 or 10% of the accrued interest.

2025 Legislation

A.B. 144 – Health: A.B. 144 is a response to recent developments at the federal level relating to preventive services. To address the changes being made at the federal level, A.B. 144 sets the preventive service recommendations in place on January 1, 2025, as a baseline.

More specifically, this bill requires that the list of immunizations, items, and services that were recommended by the United States Preventive Services Task Force (USPSTF), the federal Advisory Committee on Immunization Practices (ACIP), and the federal Health Resources and Services Administration (HRSA) that were in effect on January 1, 2025, serve as a baseline of recommendations and would authorize the State Department of Public Health to modify or supplement those baseline recommendations.

S.B. 41 - Pharmacy Benefits: This is a comprehensive bill that imposes substantial new requirements on pharmacy benefit managers (PBMs). Many of the provisions in the bill go into effect on **January 1, 2026**. Among other provisions:

- The bill imposes a fiduciary duty on the PBM with respect to both self-insured employer plans and payer clients.
- The bill prohibits "spread pricing" in contracts executed, amended, or renewed on or after January 1, 2026.
- The Department of Managed Health Care (DMHC) will create a licensure process for PBMs.
- A contract between an insurer/HMO and a PBM issued, amended, or renewed on or after January 1, 2027, or the date on which the Department of Managed Health Care has established the pharmacy benefit manager licensure process, whichever is later, shall require the PBM to be licensed and in good standing with the DMHC. The effective date of this provision may be delayed if the DMHC requires additional time to create the licensure process.
- PBMs will be restricted from requiring use of only an affiliated pharmacy, and from imposing requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy.

S.B. 40 – Health Care Coverage: Insulin: This bill prohibits a large group plan/policy issued, amended, delivered, or renewed on or after **January 1, 2026**, or an individual or small group plan/policy on or after **January 1, 2027**, from imposing cost sharing of more than $35 for a 30-day supply of an insulin prescription drug (unless excepted). The bill limits the $35 cap for an individual or small group plan/policy to only Tier 1 and Tier 2 insulin if the drug formulary is grouped into tiers.

On and after **January 1, 2026**, the bill would prohibit a plan/policy from imposing step therapy as a prerequisite to authorizing coverage of insulin, and, for a large group plan/policy, requires at least one insulin for a given drug type in all forms and concentrations to be on the prescription drug formulary.

S.B. 590 – Paid Family Leave Benefits: California's paid family leave program (PFL), provides wage replacement benefits under specified circumstances, such as when caring for a family member with a serious health condition. Commencing **July 1, 2028**, S.B. 590 expands the bases for benefits to include individuals who take time off work to care for a seriously ill "designated person." A "designated person" is defined to mean any care recipient related by blood or whose association with the individual is the equivalent of a family relationship.

To obtain these new benefits, the individual that requests the benefits must identify the designated person and, under penalty of perjury, attest to how the individual is related by blood to the designated person, or how the individual's association with the designated person is the equivalent of a family relationship.

S.B. 464 – Pay Data Reporting Failures: Existing law requires a private employer that has 100 or more employees to submit an annual pay data report to the California Civil Rights Department. This bill requires an employer to collect and store any demographic information gathered by an employer or labor contractor for the purpose of submitting the pay data report separately from employees' personnel records, and, beginning **January 1, 2027**, increase the number of job categories, as specified above, to 23. In addition, S.B. 464 requires a court to impose a civil penalty against an employer that fails to file the pay data report

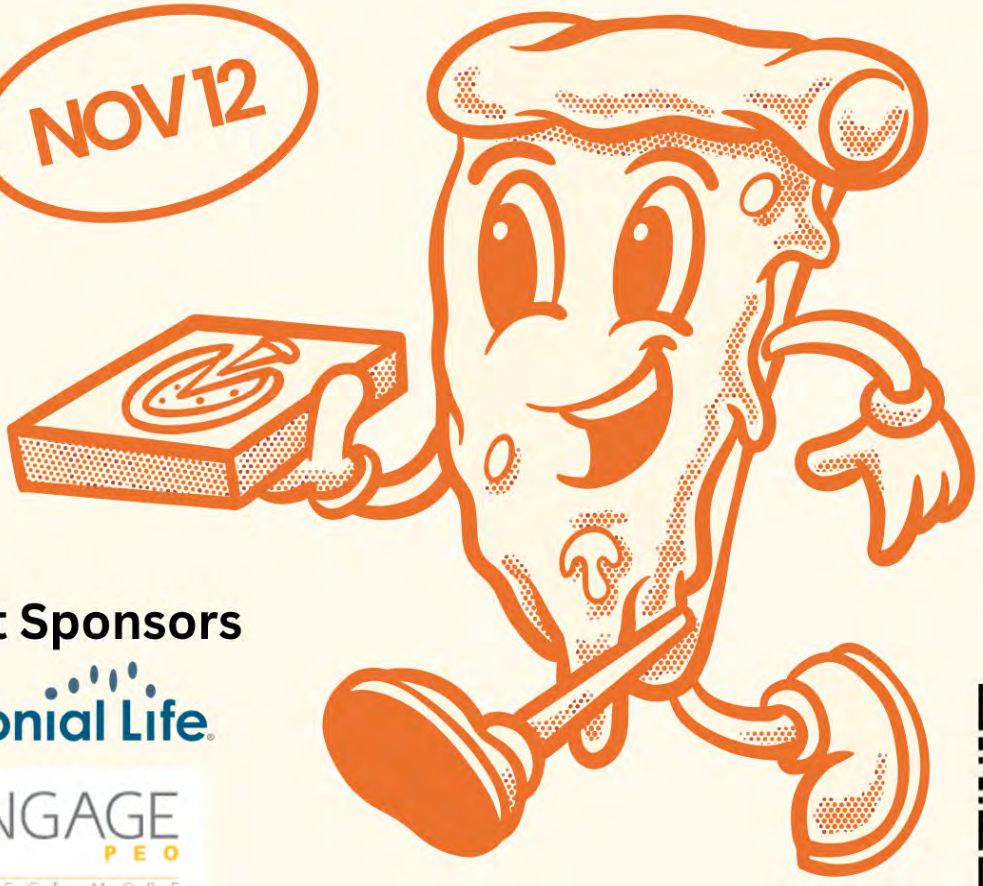
Continued on page 22

Photos From October 7, 2025 In-Person Meeting on The One Big Beautiful Bill

CAHIP
Orange County

IT'S A PIZZA PARTY

NOV 12



Event Sponsors

Colonial Life

ENGAGE PEO
EXPECT MORE

Register

FREE FOR MEMBERS • **$25 FOR NON MEMBERS** • **WEDNESDAY 5:30-7:00PM**

Sgt. Pepperoni's Pizza Store

4533 Campus Dr, Irvine, CA 92612

SPACE IS LIMITED RSVP IS REQUESTED
NO REGISTRATION AT DOOR

More Information: admin@cahipoc.org

Medicare Summit Wrap-Up

The Greatest Medicare Show on Earth!

By Margaret Stedt, CSA, LPRT, SR Summit Co-Chair

The 13th Annual Senior Summit was a great success with over 778 paid attendees! Our membership teams from all three chapters were busy signing up a total of 31 new members to NABIP. (The breakdown was 11 Orange County, 12 Inland Empire, 5 for San Diego, and 2 for Los Angeles.)

Starting out on Monday, September 9,th our popular golf event kicked off with over 62 golfers who had a shotgun start at the challenging championship Pechanga Journey golf course. Immediately following the tournament, the golfers enjoyed an awards luncheon with prizes. Meanwhile, our exhibitors and sponsors were busy setting up their booths.

On Tuesday, September 10,th we started the meeting with a Welcome kickoff from our Ringmasters: Ricky Haisha, Maggie Stedt and Yolanda Webb. Yasmine Romero opened the Summit singing "The Star-Spangled Banner." This was followed by CE classes. A big thanks to Bobbie Kaelin, PayProtpa.com (The Fraud Squad and You), Adriana Mendieta, Cybersecurity Insurance Solutions; Carl Grifka, SingerLewak (Cyber Risk, Cybersecurity & Insurance) and Paul Roberts, Word and Brown (OBBBA Budget Bill: Navigating the New Benefits Landscape).

We heard messages from our Platinum Partners, Alignment, Applied General Agency and SCAN Health Plan. They made the Summit possible with their generous support! They were featured in our Exhibit Hall that opened after lunch.

We then addressed "Our Wins with NABIP and CAHIP." We heard some great information from our panel moderated by Chalen Jackson from the McNerney Management Group. Thank you to Dwane McFerrin (SMS), Amanda Brewton, Medicare Answers Now, Nick Uehlecke, The Todd Strategy Group, Calvin Bagley, Nuvo Health, and Faith Borges, CAHIP Lobbyist, for being on the panel.

We wrapped up the day with three CE classes. Thank you to Bobbie Kaelin, PayProtpa.com (Aging Population and serving/Service Ethically), Tim Kanter (Agency Evolution: Build Smart, Scale Strategically, Exit Strong), and David Garcia and Mary King, Warner Pacific (Employee Benefits vs Medicare Benefits, Should Your Employees Stay or Should They Go?). At day's end, our attendees were treated to a Happy Hour presented by Blue Zones Health.

Wednesday, September 10th opened with a T Shirt toss and was followed by three presentations, of which two were CE classes. A big thank you to our presenters Bobbi Kaelin, ProProtpa.com (Ethics), Maura Zamarippa, AMWINS Connect (Increase your Revenue Through Employee Benefits Market), and Korey Ashton, Kizen (AI From Concept to Reality). This was followed by the Medicare Legislative Outlook & Challenges Panel moderated by Chalen Jackson, McNerney Management Group. Our panelists included Susan Rider - NABIP President; Calvin Bagley, Nuvo Health, Amanda Brewton, Medicare Answers Now; Dwane McFerrin, Senior Market Sales; and Nick Uehlecke, Todd Strategy Group.

For the first time, we addressed Errors and Admissions coverages and concerns with Drew Potter, Inszone Insurance Services, and Chalen Jackson, McNerney Management Group. This presentation was followed by Nick Uehlecke who shared updates and challenges in Washington DC. He outlined the development and goals of the newly introduced Broker Bill by U.S. Senators Mike Rounds (R-S.D.) and Catherine Cortez Masto (D-Nev.) The bill titled the *Independent Broker Relief and Oversight of Knowingly Egregious and Repetitive Sales Tactics in Medicare Enrollment* (BROKERS TIME) Act of 2025, would update the definition of third-party marketing. (Note: There was a recent "Operation Shout" from NABIP asking for support of this bill.)

Continued on page 23

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***


CAHIP
Orange County
Holiday
Harbor Cruise
MUSIC. FOOD. DRINK.
5:00 PM - 8:00 PM
09 DECEMBER 2025
400 MAIN STREET, NEWPORT BEACH
EARLY-BIRD REGISTRATION (10/01-11/14/2025)
MEMBERS . $65 . NON-MEMBERS . $90
www.cahipoc.org
TOY DRIVE
Please Bring Cash or Gift Cards to Target/ Walmart
REGISTER

Choose a health care partner that's better for your business today, and tomorrow.

Remote, hybrid, in-person. Today's workforce needs care that meets them where they are. More than ever, workforce health is a business strategy. Choose a leader who can help you navigate challenges and capitalize on emerging opportunities. Learn more at **kp.org/business**

For all that is California. For all that is you.

KAISER PERMANENTE® | Business

Applied General Agency, Inc. launched in 1993 and has grown to become **one of the largest Medicare-focused National Marketing Organizations in the nation.**

- Top-Tier Carrier Contracts
- Hands-On Support & Mentorship
- Turnkey Marketing Programs
- Exclusive Events & Training
- Tech & Tools That Power Your Business
- Compliance Guidance You Can Count On

Scan to Get Contracted!

30+ YEARS OF LEGACY

"The AGA philosophy came to me while still an Independent Agent. That is: If you're helping, you're selling. If you're just selling, you may not be helping."
–Patrick Rodriguez, CEO & Founder

Our Mission

AGA's mission is to empower agents and agencies in the Medicare industry with top-tier training, technology, and sales tools. By partnering with AGA, you'll spend less time doing things that don't make you money, and more time doing things that do.

We know that running a successful business can be tough. Time constraints and a lack of resources can hold you back from reaching your full potential. At AGA, we remove the hurdles preventing you from success and provide you with the tools and support you need to succeed.

Happy Holidays From Your

CAHIP-OC

Board of Directors!

The Leading Producers Round Table

The best of the best. That's what the Leading Producers Round Table (LPRT) is for America's benefit specialists. It's where the nation's best performers in the business get recognized for their leadership and rewarded for their accomplishments … with tools and benefits that will help keep them at the top of their game.

Only members of the National Association of Benefit Insurance Professionals (NABIP) can quality. So, if you like the view from the top, visit us online for more information about the privileges and rewards of being an LPRT member.

NABIP
Shaping the *future* of healthcare

http://www.nabip.org/membership-resources/lprt-leading-producers-round-table

Legal Briefs, Continued from Page 14

if requested to do so by the department.

S.B. 446 – Data Breach Notifications: California has, for many years, its own data breach law. (Most other states also have their own data breach law.) S.B. 446 modifies existing state law to require that data breach disclosures be made generally within 30 calendar days of discovery or notification of the data breach (with some exceptions). In addition, under existing law, disclosures also have to be made to the Attorney General in some instances. S.B. 446 requires that mandatory submissions to the Attorney General be made within 15 calendar days of notifying affected consumers of the security breach.

Mandated Benefits: Many mandated benefit bills made their way to the governor's desk this year. Apart from S.B. 40 (discussed above), he vetoed most of them. The bills he vetoed include:

- ***A.B. 432 – Menopause***: This bill would have required certain plans/policies to cover the costs of evaluation and treatment options for symptoms of perimenopause and menopause, as deemed medically necessary by a health care provider.
- ***A.B. 546 - Portable HEPA Purifiers***: This bill would have required, in specified instances, a large group plan/policy to include coverage for one portable high-efficiency particulate air (HEPA) purifier for an enrollee or insured who is pregnant or diagnosed with asthma or chronic obstructive pulmonary disease if the enrollee or insured is residing in or displaced from a county where a local or state emergency has been declared due to wildfires and the HEPA purifier is prescribed by a health care provider. The bill would have placed an outside limit on the cost of the purifier.
- ***A.B. 554 - Antiretroviral Drugs, Drug Devices, and Drug Products***: This bill, the Protecting Rights, Expanding Prevention, and Advancing Reimbursement for Equity (PrEPARE) Act of 2025, would have prohibited a plan/policy from subjecting antiretroviral drugs, drug devices, or drug products that are medically necessary for the prevention of HIV/AIDS, to prior authorization or step therapy, but would have authorized prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy.
- ***A.B. 1032 - Coverage for Behavioral Health Visits***: This bill would have generally required a large group plan/policy to reimburse an eligible enrollee or insured for up to 12 visits with a behavioral health provider if the enrollee or insured lives in a county where a local or state emergency has been declared due to wildfires and the enrollee or insured has experienced a loss, trauma, or displacement because of the fire—without utilization review.

##

More Senior Summit Photos

Senior Summit Wrap-Up, Continued From Page 17

In our Medicare Nugget moment, Aileen Costello Dewar presented information about the new requirements that for California employers with fewer than five employees. They are not required to offer a 401(k) plan, but they must provide employees with access to a retirement savings plan by a deadline of December 31, 2025.

Our next panel, "PDP Sales Dilemma – Sell or Not to Sell Question," held a great discussion on the challenges faced by our agents in the sales and servicing of their clients' PDP plans. Our panelists included Henry Romero- HRBC, Dr. Chiriboga (AltaMed), Tamie Mongold, Shop N Health Insurance Agency, Matt Fletcher (MF Insurance Services), and Dr. Ali Farrokhroo (Alignment). Austin Felch, AGA served as our Moderator.

Gabrielle Rascon with Applied General Agency shared some great ideas on the use of AI in her presentation titled "The Future of Marketing."

Our last panel of the day was led by Hana Eicher of AGA, who addressed "How Agents and Providers Can Work Together." Our panelists included Leslie Tribble (Alignment), Jill Selby (Regal), Donna McKeehan (Anthem), and Austin Felch (AGA).

The day ended with three educational sessions presented by Dany Galigan (Digital Marketing Unlocked: Turning Chaos into a Clear Plan), Blue Zones Health, and Henry and Nico Romero, HRBC Insurance Services (Technology for the Medicare Insurance Agent/Agency).

Attendees enjoyed dinner on their own and many attended the SCAN and AGA Reception at the Journey.

Thursday opened with Yasmine Romero's beautiful rendition of "Proud to Be an American" in memory of September 11, 2001 (9/11) and our past and current service members. The rest of the day was all about the plan offerings and changes for 2026! Many carriers shared their First Looks and key things to know about selling their plans in 2026. They included Alignment. SCAN, Molina, Humana, WellCare, Champion Health Plan, Aetna, United Healthcare, Anthem Blue Cross, and Blue Shield. The event closed with multiple thank yous and a Grand Prize award to one lucky attendee! Congratulations to SCAN for winning the contest for the best themed exhibitor booth!

We are so grateful for the support and participation of our Sponsors and exhibitors. Our sponsors included Alignment, Applied General Agency, SCAN Health Plan, Molina HealthCare, Humana, WellCare, Jack Schroeder and Associates, Blue Zones Health, Senior Market Sales, Kizen, Financial Grade, HRBC Insurance, AgentMethods, AltaMed, Champion Health Plan, Regal Medical Group, Lakeside Community Healthcare and ADOC Medical Group, Primary Care Associates of California, Aetna Medicare Solutions, Quotit, LA Care, Enable Dental, The Brokerage Inc., Optum, Syndicated Insurance Agency LLC, Clever Care Health Plan, Welbe Health, and Retire with Renewals.

The Circus theme was exciting and colorful, with our attendees enjoying the great decorations. Check out the pictures on our website: theseniorsummit.net. The Exhibit Hall was bigger and better than ever! The T-Shirt Toss, masterminded by Yolanda, was a big hit with the crowd!

If you have suggestions, or want to volunteer for next year, please don't hesitate to contact us! I may be reached at mstedt@stedtinsurance.com and exhibitors and sponsors may contact Gail at seniorsummit@yahoo.com.
Your Senior Summit Team is already busy evaluating the attendee surveys and starting the planning for next year! We will soon be determining proceeds to our three chapters to help with the costs for our members to attend the NABIP and CAHIP Capital Events and membership campaigns.

A big thank you to our Senior Summit Team (Dawn Carroll, Gail James Clarke, George Carson, Ricky Haisha, Yolanda Webb, Juan Lopez, Henry Romero, Craig Gussin and me). And, also a well deserved thank you to all our volunteers, including our Security Team!

Can't wait to see you at the Summit in 2026! ##

Rounds Introduces Legislation to Support Seniors' Access to Medicare Enrollment Assistance

The Broker Bill is a key piece of legislation for the long-term viability of our business as agents. U.S. Senator Mike Rounds (REP) and Senator Catherine Masto (DEM) who are co-sponsoring this bill, are committed to push this as part of a government reopening and the end of year bill. Your Senior Summit Team and other NABIP members (Ricky Haisha, Yolanda Webb, Erin Fisher, Dwane McFerrin and myself with some others) were instrumental in assisting in the crafting of this legislation. With everyone's support through NABIP's Operation Shout, let's take it to the finish line!

WASHINGTON – U.S. Senators Mike Rounds (R-S.D.) and Catherine Cortez Masto (D-Nev.) introduced the *Independent Broker Relief and Oversight of Knowingly Egregious and Repetitive Sales Tactics in Medicare Enrollment* (BROKERS TIME) Act of 2025. This legislation would update the definition of a third-party marketing organization to distinguish between call centers and an independent agent or broker. This is an important distinction that determines whether local, independent agents are regulated the same way as large, high-volume call centers.

For the full press release, go to: ***https://www.rounds.senate.gov/newsroom/press-releases/rounds-introduces-legislation-to-support-seniors-access-to-medicare-enrollment-assistance***

California Agents and Health Insurance Professionals Political Action Committee
1127 11th Street, Suite 210
Sacramento, CA 95814
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 1127 11th Street, Suite 210 Sacramento, CA 95814**
Questions: **(800) 322-5934**

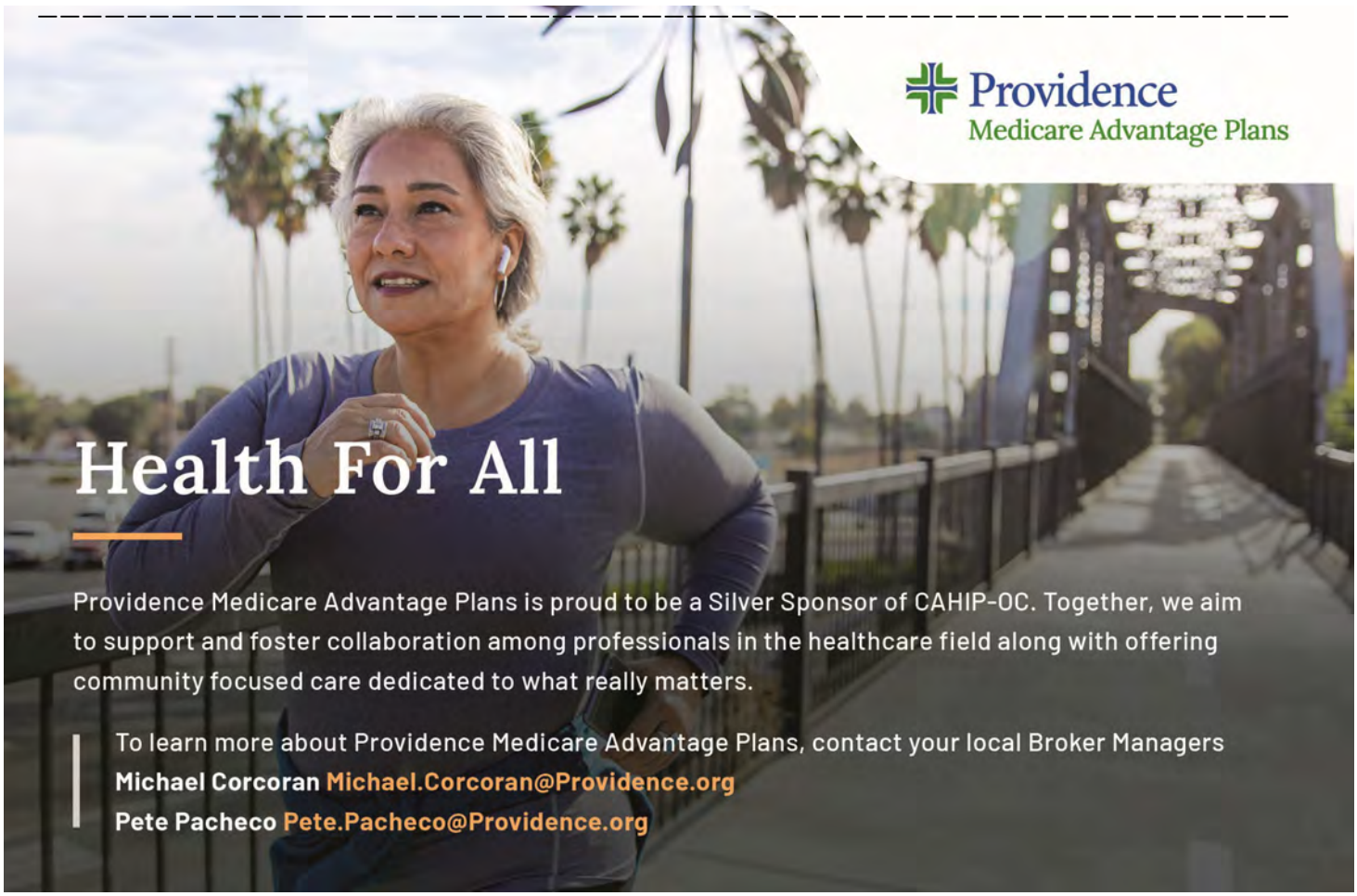
OneCare
CalOptima Health

CalOptima Health OneCare is Proud to Sponsor CAHIP-OC

CalOptima Health OneCare (HMO D-SNP) is built around Orange County's Medi-Medi community, uniting members with the support network they need. We strive to promote and strengthen collaboration among health care professionals, highlighting our commitment to support those who serve our members.

To learn more about CalOptima Health OneCare, contact us at **broker@caloptima.org** or visit **caloptima.org/OneCare**.

CalOptima Health, A Public Agency



Senior Summit 2025 Photos

More Photos on Pages 22, 27, 34, 36, 38, 41, 43

HIPAA Updates, continued from page 12

health information privacy rights or committed another violation of the Privacy, Security, or Breach Notification Rules, you may file a complaint at https://www.hhs.gov/hipaa/filing-a-complaint/index.html To subscribe to or unsubscribe from the list serv, go to https://list.nih.gov/cgi-bin/wa.exe?SUBED1=OCR-PRIVACY-LIST&A=1

On August 11, 2025, HHS/OCR Released a **New and Updated HIPAA Privacy Rule Frequently Asked Questions**

The U.S. Department of Health and Human Services, Office for Civil Rights, issued deregulatory guidance in the form of frequently asked questions (FAQs) about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. The HIPAA Privacy Rule establishes national standards to protect individually identifiable health information, sets limits and conditions on the uses and disclosures of protected health information (PHI), and gives individuals certain rights, including the right to timely access and to obtain a copy of their health records.

The FAQs support the Centers for Medicare & Medicaid Services' July 30, 2025 announcement regarding the creation of a patient-centric, digital health care ecosystem that will improve patient outcomes, reduce provider burden, and drive value. Specifically, the HIPAA FAQs address how covered health care providers are permitted to disclose PHI to value-based care arrangements for treatment purposes, and what health information is included in a designated record set and thus subject to the individual's right to access such information.

New and Updated FAQs:

New. Does the HIPAA Privacy Rule permit a covered health care provider to disclose protected health information to value-based care arrangements, such as accountable care organizations, for treatment purposes without the individual's authorization?

Updated. What personal health information do individuals have a right under HIPAA to access from their health care providers and health plans?

In addition to the Privacy Rule, OCR enforces the HIPAA Security and Breach Notification Rules. These rules, collectively known as the HIPAA Rules, set forth the requirements that covered entities (health plans, health care clearinghouses, and most health care providers) and business associates must follow to protect the privacy and security of PHI. Guidance about the HIPAA Privacy Rule, Security Rule, and Breach Notification Rule can be found on OCR's website.

If you believe that your or another person's health information privacy or civil rights have been violated, you can file a complaint with OCR at https://www.hhs.gov/ocr/complaints/index.html.

Follow HHS OCR on X (formerly Twitter) at @HHSOCR.

This email is being sent to you from the OCR-Privacy-List listserv, operated by the Office for Civil Rights (OCR) in the US Department of Health and Human Services. This is an announce-only list, a resource to distribute information about the HIPAA Privacy, Security, and Breach Notification Rules. For additional information on a wide range of topics about the HIPAA Rules, please visit https://www.hhs.gov/hipaa/index.html. Information about OCR's civil rights authorities and responsibilities can be found at https://www.hhs.gov/civil-rights/index.html. If you believe that a HIPAA-covered entity or its business associate violated your (or someone elses) health information privacy rights or committed another violation of the Privacy, Security, or Breach Notification Rules, you may file a complaint at https://www.hhs.gov/hipaa/filing-a-complaint/index.html To subscribe to or unsubscribe from the list serv, go to https://list.nih.gov/cgi-bin/wa.exe?SUBED1=OCR-PRIVACY-LIST&A=1.

Look for more updates in the next issue of the COIN!

##

Senior Summit Photos

2025-26 Board of Directors

Sarah Knapp
President
Colonial Life

Gonzalo Verduzco
President-Elect
FFG

Barbara Ciudad
Immediate Past-President

Dorothy Cociu
VP Communication
Advanced Benefit Consulting

Juan Lopez
VP Finance
JRL Benefit Solutions

Haley Mauser
VP Membership
Optavise

Tracy Hanson
VP Legislation
Blue Shield of CA

Cathy Daugherty
VP PAC
BAIS

Gabriella Bellizzi
VP Professional Development
Amwins Connect

Becky Capelouto
Awards
Sunrise Express Insurance

Maggie Stedt
Medicare Liaison
Stedt Insurance

Linda Madril
Media Relations

Melissa Calabretta
Member Retention
JLR Agency

John Austin
New Member Liaison
CHOICE

Patricia Stiffler
Public Service
Options in Insurance

John Evangelista
Sales Symposium
Colonial Life

Ailene Dewar Costello
Social Media
Engage PEO

Anne Kelly
Sponsorship
Kelly and Kelly

Gail James Clarke
Executive Director
Gail James Assoc Mgmt

Board contact info @ www.cahipoc.org

Membership has its "Awards"

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 - NEW MEMBERS

Terry Anguiano Reed
Debbie Elmer
Shiela Hamilton
Lizbeth Lopez
Keisha Smith

Andrew Bender
Daniel T Frey
David G Horne
Todd W Macaluso
Robin S Wotipka

Glenda R Collins
Patricia Farcia
Florest Koulo
Jennifer Navarro Mian
Pascal Zandt

Thanks, New Members!

Contact our Membership Team:

Haley Mauser, VP of Membership
Optavise, (707) 628-9260
Haley.Mauser@optavise.com

Talk to a Board Member
(see page 28 for board roster)

Visit our website at www.cahipoc.org

Many ways to join!

Agency Memberships Now Available!

JOIN CAHIP-OC

NABIP | pac

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:
  - Candidate Account
  - 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 31!

Note: CAHIP PAC contribution form can be found on page 24!

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:

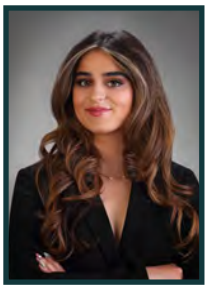
Step 4: Submit this form.

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.



Where Are the Young People? Confronting the Generational Gap in American Insurance

By Gabriella Bellizzi, VP of Professional Development

The American insurance sector—spanning life, health, property and casualty lines—stands at a critical inflection point. While the industry continues to contribute over $1.4 trillion in annual premiums and employs nearly 3 million professionals, its labor force remains demographically imbalanced and generationally skewed (Insurance Information Institute [III], 2024). Most notably, the sector is aging precipitously: recent estimates place the average age of an insurance agent at 45.9 years, with over two-thirds of industry professionals aged 40 or older (LegacySpire, 2024). Simultaneously, fewer than 25% of employees are under 35, signaling a looming talent vacuum as an estimated 400,000 insurance professionals are projected to exit the workforce by 2026 (Jacobson Group & Aon, 2025).

This demographic trajectory is not merely a challenge of succession planning—it represents a deeper, systemic failure to render the profession intelligible, appealing, or accessible to younger generations.

Understanding Youth Disengagement: Structural and Perceptual Barriers

Empirical data and qualitative analyses suggest that the underrepresentation of Millennials and Gen Z in insurance is not a reflection of capability or fit, but of systemic opacity and under-communication. In Accenture's 2025 study on generational workforce engagement, fewer than 20% of U.S. college students could name more than one professional role in insurance beyond "agent." A companion study by The Institutes (2024) found that younger professionals frequently describe the industry as "complex," "inflexible," and "functionally invisible" within broader economic narratives. These findings are reinforced by the labor market analysis published by the Jacobson Group in January 2025, which found that only 16% of insurers expected to hire for entry-level roles, marking a historic low. This hiring hesitancy not only limits accessibility, but also perpetuates an implicit bias toward mid-career professionals, further deterring young entrants.

Cultural dissonance compounds this issue. As digital natives, Gen Z and younger Millennials expect purpose, adaptability, and visibility in their work. Insurance, despite being integral to economic resilience and climate risk mitigation, has not successfully repositioned itself as a vehicle for societal impact. Consequently, the sector is losing talent not to disinterest, but to industries with more effective narrative strategies—particularly technology, consulting, and sustainable finance.

Constructing Viable Entry Pipelines: The Strategic Role of Development Programs

Despite these challenges, structural solutions are emerging—and in some cases thriving—within the industry's margins. Leading firms such as Travelers, USI Insurance Services, AIG, and Amwins have developed high-touch, early-career programs that combine rotational exposure, technical training, and embedded mentorship to prepare recent graduates for long-term success. For example, Travelers' Claim University (Claim U) offers one of the most comprehensive onboarding ecosystems in the field, while AIG's Insurance Academy represents a multi-year investment in cultivating talent across underwriting and actuarial disciplines.

Complementing these corporate initiatives are strategic partnerships with academia, designed to bridge the gap between classroom theory and real-world application. State Farm's Research and Development Center at the University of Illinois Urbana-Champaign exemplifies this approach by immersing students in applied analytics and product modeling projects that reflect actual business challenges. Similarly, Amwins—a leading wholesale distributor of specialty insurance products—offers early-career programs such as the Connect Development Program (CDP) and the Underwriter Development Program (UDP), each providing a 2.5-year track designed for recent graduates and early-career professionals pursuing a long-term career path. The Amwins Internship Program, meanwhile, gives college students hands-on experience through real projects across core business lines. Together, these programs do more than provide entry points; they actively dismantle the perceived complexity of the industry through hands-on, experiential learning, making insurance careers more accessible and engaging for the next generation.

Although some are taking large strides in means to connect generations, programs remain underutilized by students and early-career job seekers. A lack of national visibility, coupled with fragmented outreach strategies, means that many remain unaware of these opportunities. As such, the challenge is not one of innovation, but of signal strength and infrastructural cohesion.

A Call to Action: Transparency, Mentorship, and Narrative Recalibration

The imperative now is twofold: first, the industry must engage in radical transparency about the learning curve, compensation structures, and advancement pathways inherent in insurance careers. Unlike sectors that promise rapid mobility or glamour, insurance offers durability, intellectual breadth, and systemic impact—but only if these features are rendered legible to young audiences.

Second, companies must elevate youth voices internally and amplify them externally. Peer-to-peer narrative framing—testimonials, video diaries, professional development journeys—will be more persuasive than institutional branding alone. Moreover, mentorship

Continued on Page 34

SPECIAL THANKS TO OUR ANNUAL CORPORATE SPONSORS!

Titanium Level

KAISER PERMANENTE®

aga
AN INTEGRITY COMPANY

health net

Gold Level

OneCare
CalOptima Health

Silver Level

Regal
Medical Group, INC.

Bronze Level

CRC BENEFITS

Providence
Medicare Advantage Plans

Retire *with* Renewals

Word&Brown.

Where Are The Young People?, Continued From Page 32

models must be systematized and decoupled from informal networks that often exclude underrepresented talent.

Finally, more insurers must invest in community college pipelines, micro-internships, and high school engagement to capture a wider spectrum of potential entrants—particularly those whose skills align with digital transformation, behavioral data analytics, and customer experience strategy.

A Learning Curve Worth Climbing

The insurance industry doesn't lack opportunity. It lacks translation. For a generation accustomed to immediate impact and fluid career paths, insurance must become narratively accessible—positioning itself as a high-stakes, intellectually rich, and socially impactful career choice. Early-career talent doesn't need a perfect roadmap—but they do need visibility, mentorship, and the assurance that their growth will be nurtured. The opportunity is vast, the industry is evolving, and the stakes—climate risk, cyber security, global resilience—have never been higher.

This moment calls for more than recruitment. It calls for redefinition. If the industry can rise to that challenge, it will find in Gen Z not just a stopgap, but a renaissance.

Interested in The 'Early' Career Insurance Programs? :

Amwins early Development Programs & Internships: https://www.amwins.com/who-we-are/career-resources

Travelers Early Career Programs: Claims Jobs at Travelers |Travelers Claims Careers | Work in Claims with Insurance Leader Travelers
AIG Early Development Programs: Students & Graduates - Careers at AIG | AIG US
State Farm Early Development programs: Research and Development Center – State Farm®
USI Early Development Programs: Early Careers | USI Insurance Services

Works Cited

Accenture. *Next-Gen Talent Trends in Risk and Insurance*. 2025, https://www.propertycasualty360.com/2025/03/21/how-to-reach-the-rising-generations-of-insurance-professionals/.

AIG. *Insurance Academy and Graduate Programs*. 2024, https://www.aig.com/careers/students.

Amwins. *Diversity and Inclusion Initiatives*. 2023, https://www.amwins.com/about/diversity-inclusion.

Amwins. *Explore RMI Internship Opportunities*. 2025, https://www.amwins.com/who-we-are/careers/internship-program.

Insurance Information Institute (III). *Facts + Statistics: Careers and Employment*. 2024, https://www.iii.org/fact-statistic/facts-statistics-careers-and-employment.

Jacobson Group, and Aon. *Q1 2025 U.S. Insurance Labor Market Study*. 2025, https://www.carriermanagement.com/news/2025/03/10/272750.htm.

LegacySpire. *How Many Insurance Agents Are There in the U.S.?* 2024, https://legacyspire.com/how-many-insurance-agents-are-there-in-the-us/.

State Farm. *Research and Development Center at the University of Illinois*. 2023, https://en.wikipedia.org/wiki/State_Farm_Research_and_Development_Center.

The Institutes. *Perceptions of Insurance Among Early Career Professionals*. 2024, https://www.theinstitutes.org.

Travelers. *Development Programs*. 2024, https://careers.travelers.com/students-grads/development-programs/.

USI Insurance Services. *Early Talent Opportunities*. 2024, https://www.usi.com/about-usi/the-power-of-one/developing-talent-careers/early-talent.

##

Senior Summit

Join the Fight: Support CAHIP PAC, the Voice of Agents

We need your help to ensure that CAHIP PAC can continue to support candidates who champion agents' work towards affordable and accessible healthcare for all Californians. The role of the insurance agent has never been more vital. Agents are the trusted professionals who guide individuals and businesses through the complexities of healthcare, making sure everyone gets the coverage they need.

To empower our agents and uphold our mission, we're setting an ambitious goal to raise $100,000 this fiscal year for CAHIP PAC. Achieving this will allow us to meaningfully support candidates who understand the importance of our industry and the pivotal role agents play in delivering quality healthcare.

Here's How You Can Make a Difference:

- **Commit to Monthly Support:** Start with a minimum of $10/month, or ideally $25+/month to make a bigger impact this year.
- **Make a One-Time Donation:** Every contribution, whether from individuals or companies, CAHIP members, and non-members, brings us closer to our $100,000 goal.

Champion Our Cause: Spread the word and rally others to contribute to the ONLY PAC dedicated to protecting and advancing the role of the agent and the work you do on behalf of your clients, here in CA.
Every dollar strengthens our ability to advocate for the agents who make healthcare accessible. Take action today by contributing at cahippac.org or by connecting with your local PAC chair to learn how you can get involved.

Changes in Group Insurance Creditable Coverage Creates An Issue for Aged Workers and Their Dependents

By Maggie Stedt, CSA, LPRT, Medicare Liaison

Due to the changes brought about under the Income Reduction Act of 2022, many employer plans will no longer be "Creditable" for the 2026 plan year. This affects many of the Bronze and Silver Group Plans.

Creditable coverage is a prescription drug plan that provides benefits that are at least as good as Medicare's. That means that the actuarial calculation for the plan meets the Medicare Part D coverage with the maximum out-of-pocket annually of $2100 and the payment split between the plan and the covered person. Medicare eligible Individuals (working aged) who have creditable coverage are allowed to delay enrolling in Medicare Part D (prescription drug coverage) without incurring a late enrollment penalty when their current coverage ends. The most common forms of creditable coverage include employer and union group health plans, Tricare, VA benefits, and Indian Health Services.

The Medicare Part D late enrollment penalty for 2025 is calculated as 1% of the national base beneficiary premium for each full month without creditable prescription drug coverage after eligibility, added to the plan's monthly premium and paid for as long as Part D coverage continues. For 2025, the national base beneficiary premium is $36.78. The 2026 amounts should be out shortly.

The working-aged and their dependents who are in a non-creditable plan, need to enroll in Medicare Part A and select and enroll in a Stand-Alone Part D plan. To enroll in Part A, they should simply call Social Security at 1 800-772 1213. They are open weekdays from 7 am to 7 pm. Or, they can set up an appointment at their local Social Security office. Most people do not pay a premium for Part A if they or their spouse have worked and paid Medicare taxes for at least 10 years

To enroll in a Medicare Stand-alone Part D plan, they may do so through www.medicare.gov to review the plans and determine how their prescriptions would be covered under plans. They may enroll for coverage once they have their Medicare ID number and Part A effective date. **Important:** For 2026 coverage, they need to enroll in the Annual Open Enrollment period from October 15th to December 7th of 2026.

Many ask how does this affect my drug coverage if I have both an employer plan and a Stand-Alone Drug plan? It depends on the size of the group and which plan you present to your pharmacy. Enrolling in a Medicare Stand-Alone Part D Plan while keeping a group health plan does not typically prevent drugs from being prescribed, but, it can impact how prescription billing is coordinated and which plan is the first or second payer for drug costs.

When an individual is enrolled in both a group health plan and a Medicare Stand-alone Part D plan, the primary and secondary payer rules depend on the employer size and status:

- If the group health plan is through current employment and the employer has 20 or more employees, the group health plan usually pays first for prescriptions, and Stand-Alone Part D Plan is secondary.
- If the employer has fewer than 20 employees, Medicare (including Part D) pays first, and the group health plan pays second.

Impact on Prescription Filling

Pharmacies and prescribers do not generally restrict prescribing drugs just because someone has Stand-Alone Part D and a group health plan.

- The prescription may be covered by either the group health plan, Medicare Stand Alone Part D, or both, depending on the coordination rules above.
- The key issue is billing: pharmacies need to know which plan is primary to bill correctly, but this does not stop prescriptions from being written.

However, if both plans pay for drugs, coordination of benefits must be handled to prevent duplicate payments and resolve coverage confusion.

As agents, to help your groups and the working-aged, make sure you download from www.medicare.gov a copy of the Medicare Booklet "Who Pays First" to grow your understanding and to provide guidance. ##

More Senior Summit Photos

Dear NABIP Member,

Unlike other organizations, NABIP's sole focus is healthcare agents. And we're putting that laser-focus into action every day. Here are the concrete steps we're taking on your behalf:

Direct Advocacy in Washington

NABIP staff and member leaders meet weekly and privately with congressional offices, CMS officials, and state insurance commissioners to make one urgent point: cutting or capping agent compensation directly harms their constituents. We connect the dots for lawmakers between agent commissions and livelihoods, a stable Medicare market, and seniors losing access to trusted guidance during AEP.

At numerous CMS meetings over the last year, we highlighted how carriers across the board have reduced commissions and restricted plan displays on electronic enrollment platforms—moves that undermine agent support and confuse beneficiaries. We asked CMS to prohibit carriers from changing plan displays or posted commissions after October 1.

Legislation to Protect Agents

NABIP worked with Congress to introduce and advance bills that defend independent brokers and beneficiaries, including:

Senate Bill (SB) # 2625 Support Independent BROKERS TIME Act of 2025: draws a clear line between licensed, independent agents and third-party marketing organizations, ensuring regulators do not lump ethical brokers into the same category as high-volume call centers.

House Resolution (HR)# 2744 Medicare Enrollment Protection Act: prevents late-enrollment penalties for seniors transitioning from COBRA to Medicare.

Ideas for federal bills on agent compensation continue to be shopped around in supportive congressional offices and are a priority in our discussions.

NABIP files detailed responses that include your real-world experiences and push back on policies that erode agent pay.

Additional On-the-Ground Engagement

- NABIP engages with insurance companies on how to best address market pressures and avoid using agent compensation as a lever to achieve line-of-business stability.
- NABIP is representing you at the National Association of Insurance Commissioners (NAIC) meeting with state regulators this fall to press for stronger protections on compensation. At every NAIC meeting, we have important conversations with regulators on topics where we share common goals (i.e. misleading and aggressive consumer marketing campaigns).
- At national industry events like Medicarians, NABIP showcases the critical role of ethical, licensed agents and builds stronger relationships with carriers to push back against unfair practices.

Brokers Making a Difference: Stories in Action

NABIP has now collected 14,000+ stories from agents and beneficiaries. These aren't just for show, as they are used as:

- Congressional testimony and talking points when we meet with lawmakers.
- Letters to regulators demonstrate how policy decisions affect real people.
- Narrative-correcting evidence for research reports from groups like MedPAC, the Commonwealth Fund, and the Paragon Institute help ensure that agent experiences shape long-term Medicare policy.

Looking Ahead: Priorities for Compensation

NABIP has a clear set of legislative and regulatory priorities to guide your conversations with lawmakers ahead of AEP, centered on:

- Protecting fair and stable agent compensation.
- Preventing market instability caused by carrier decisions on plan availability and compensation decisions.
- Preserving beneficiary choice and affordability, which are directly tied to agent advocacy.

NABIP is making sure policymakers and market players know that reducing or undermining agent compensation is bad for you, your family, and every Medicare beneficiary who needs your help.

NABIP Government Affairs

National Association of Benefits and Insurance Professionals

Phone: 202-552-5060

info@nabip.org **www.NABIP.org**

Special Thanks to Our

Bronze Level

Corporate Sponsor

CRC BENEFITS

Senior Summit

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!

Pizza Party, November 12, Sgt Pepperoni's, Irvine

Holiday Cruise, December 9, Newport Beach

Annual Sales Symposium, March 10, 2026

CAHIP Legislation Report

By: Tracy Hanson, VP of Legislation

The CAHIP Legislation Committee was busy this past summer tracking the many health bills in the state Assembly and Senate. In July, we launched a Voter Voice campaign in opposition to **SB 354**, a bill that would impose onerous privacy reporting requirements on all agents. We succeeded in getting the bill designated as a two-year bill and it will not advance until January 2026.

The Committee reviewed ten additional bills, and the CAHIP Board of Directors approved their recommendations, adding three of the bills to our Priority Bill Report. During the federal August recess, CAHIP leadership held virtual meetings with staff from U.S. Senators Alex Padilla and Adam Schiff's offices. This was part of NABIP's August Advocacy campaign. We addressed the vital role of agents especially as it relates to the Premium Tax Credits (PTCs) and changes to the Medicare Annual Enrollment Period. Additionally, we asked for their support on **H.R. 2744** – Medicare Enrollment Protection Act which would provide for COBRA as Creditable Coverage, and **S.2625** – Independent BROKERS TIME Act of 2025. CAHIP recently signed onto a coalition letter intended for the CA Congressional delegation. The letter urges them to support an extension of the PTCs.

On September 15, 2025 CAHIP wrote to Governor Gavin Newsom requesting a signature of **AB 489 (Bonta)** which strengthens consumer confidence in California's healthcare system by establishing clear and necessary boundaries around the use of artificial intelligence in healthcare communications. This bill supports transparency in health communications, which is fundamental to preserving public confidence in our healthcare system. It also reinforces the trusted role of licensed professionals—such as insurance agents, physicians, and nurses—by ensuring that titles reserved for these individuals are not misused by automated systems. AB 489 helps ensure that consumers can clearly distinguish when they are receiving information or guidance from a licensed medical professional versus an AI-powered system. This transparency is critical for informed decision-making and public trust in licensed experts, including health insurance agents and medical providers. CAHIP is committed to protecting consumers and promoting responsible innovation. AB 489 strikes the right balance by supporting technological advancement while safeguarding Californians from misleading or potentially harmful representations.

On September 16, 2025 CAHIP wrote to Governor Gavin Newsom urging him **veto AB 943 (Rodriguez)**. While we recognize that this bill is sponsored by a fellow agent organization—and we respect their commitment to expanding access to our profession—we believe AB 943 raises significant concerns regarding consumer protection and the integrity of professional standards.

California's pre-licensing education requirements were established to address past challenges in our industry, where insurance agents were often perceived more as salespeople than as trusted advisors and consumer advocates. The introduction of standardized training in ethics, insurance law, and product knowledge has elevated professionalism, enhanced public trust, and improved the service Californians receive.

AB 943 would undermine these hard-earned gains at a time when consumers are already facing serious challenges related to access and affordability. These educational requirements have not only improved compliance but also empowered consumers to make better-informed choices. Weakening these safeguards would be a step backward for both our profession and the public we serve. ##

Happy Thanksgiving!

CAHIP-OC Board of Directors

NABIP
Healthcare Happy Hour

Subscribe to NAHU's Healthcare Happy Hour

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

Latest Podcasts:

- **House Ways & Means Committee Advances NABIP Federal Priority to Ease Employer Reporting Process**
- **Are you Ready for NABIP's Annual Convention?**
- **How to Best Leverage Employee Benefit Portfolios—from Retirement Plans to Pet Insurance**
- **A Stay inn ACA Preventive Care Mandate Case: NABIP Submits More Testimony**
- **What You Need to Know About the End of the COVID-19 Emergency Periods**
- **NABIP Submits Written Testimony on Host of Healthcare Issues**
- **Special Guest from Nonstop Health Discuss Benefits for Brokers and Employers**
- **An Individual Market Agent's Perspective on the Medicaid Unwinding**

Follow CAHIP-OC on Social Media!

https://www.facebook.com/CAHIPOC/

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

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

Hold the Date!

CAHIP-OC

Annual Sales Symposium

March 10, 2026

CAHIP
Orange County

Don't Forget to Register…

Pizza Party, November 12

And

Holiday Cruise, December 9

Register at: *www.cahipoc.org*

CAHIP Orange County | Membership Matters
"If You Know, You Know" – Join the Momentum

By: Haley Mauser, John Austin and Melissa Calabretta
CAHIP-OC Membership Team

Many of you may ask what our tagline means *"If You Know, You Know"* to those of us in membership. Quite simply, it means that if you've invested in being part of this organization, then you already understand just how essential that membership is. You know the value, the support, and the advocacy we can't live without.

One of the most important ways that value shows up is through the power of our collective voice and that brings us to why it's so important to **share the value of membership and invite others to join CAHIP/NABIP today.**
Membership in CAHIP/NABIP is more than just professional affiliation, it's our strongest line of defense in protecting the future of our industry. As dedicated insurance professionals, we serve as trusted advisors to individuals, families, and employers. But that role is under threat.

With recent moves by insurance carriers to eliminate agent compensation for Medicare and select marketplace plans, consumer access to expert guidance is at risk. We've seen similar challenges before during the rollout of the ACA and Covered California when decision-makers underestimated our value and attempted to replace us with navigators. Our organization stepped in then, and it's stepping in now.

CAHIP/NABIP tirelessly advocates for us at both the state and federal levels, influencing legislation and regulation that directly affects how we do our jobs. Without their support, many of the protections and roles we rely on could have been lost.
This is why it's critical to not only stay involved but to actively share the value of membership with your peers. The more voices we have, the stronger our advocacy becomes. When you invite others to join, you're helping safeguard the future of our profession and ensuring that consumers continue to receive the guidance they deserve.

With that in mind, we're excited to welcome the newest members to CAHIP Orange County!
Their decision to join strengthens our collective voice and brings fresh energy to our mission.

Terry Anguiano Reed	**Andrew Bender**	**Glenda R Collins**
Debbie Elmer	**Daniel T Frey**	**Patricia Farcia**
Shiela Hamilton	**David G Horne**	**Florest Koulo**
Lizbeth Lopez	**Todd W Macaluso**	**Jennifer Navarro Mian**
Keisha Smith	**Robin S Wotipka**	**Pascal Zandt**

Whether you're a long-time member or just getting started, every single one of us plays a vital role in shaping the future of our industry and we're thrilled to have these new members alongside us on that journey.

To our newest members: welcome. To everyone else thank you for continuing to share the value of this community.
Now you know.

##

Senior Summit Photos

National Association of Benefits and Insurance Professionals

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

Earning the Registered Employee Benefits Consultant® (REBC®) designation elevates your credibility as a professional. The field of employee benefits continues to evolve rapidly. A year does not go by without new government regulations, new or modified coverages, and new techniques for controlling benefit costs. To best serve their clients, professionals need to have a current understanding of the provisions, advantages, and limitations associated with each type of benefit or program as a method for meeting economic security. The designation program analyzes group benefits with respect to the ACA environment, contract provisions, marketing, underwriting, rate making, plan design, cost containment, and alternative funding methods. The largest portion of this program is devoted to group medical expense plans that are a major concern to employers, as well as to employees. The remainder of course requirements include electives on topics serving various markets based on a broker's client needs . ***Earn yours now!***

Senior Summit Photos

Don't Miss Our Upcoming Programs!

Pizza Party

November 12, 2025

Sgt Pepperoni's, Irvine

5:30-7:00 pm

Holiday Cruise

December 9, 2025

5 to 8 pm

Newport Beach

PRSRT STD
U.S. POSTAGE
PAID
ANAHEIM, CA
PERMIT #815

- THE C.O.I.N. -

Don't miss our upcoming events!

UPCOMING EVENTS

CAHIP-OC PIZZA PARTY, NOVEMBER 12, 2025, ST. PEPPERONI'S PIZZA, IRVINE

CAHIP-OC HOLIDAY CRUISE, DECEMBER 9, NEWPORT BEACH

CAHIP-OC ANNUAL SALES SYMPOSIUM, MARCH 10

Visit our website for more details

www.cahipoc.org

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