IN PERSON & VIRTUAL BOARD MEETING

MAY 21, 2025 AT 9:00 AM
BOARD OF RETIREMENT MEETING

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TO PROVIDE PUBLIC COMMENT

Members of the public may address the Board orally and in writing. To provide Public Comment, please visit the above link and complete the request form.

Attention: If you have any questions, you may email PublicComment@lacera.com.

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION
300 N. LAKE AVENUE, SUITE 650, PASADENA, CA

AGENDA

A SPECIAL MEETING OF THE BOARD OF RETIREMENT AND

BOARD OF INVESTMENTS

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

WESTIN LONG BEACH | 333 E. OCEAN BLVD., LONG BEACH, CA 90802

9:00 A.M., WEDNESDAY, MAY 21, 2025

This meeting will be conducted by the Board of Retirement and Board of Investments both in person and by teleconference under California Government Code Section 54953(f).

Any person may view the meeting online at
https://LACERA.com/leadership/board-meetings

The Boards may take action on any item on the agenda, and agenda items may be taken out of order.

9:00 a.m. **Call to Order**

Pledge of Allegiance

Procedure for Teleconference Meeting Attendance Under AB 2449, California Government Code Section 54953(f)

A. Just Cause
B. Action on Emergency Circumstance Requests
C. Statement of Persons Present at AB 2449 Teleconference Locations

Public Comment
(Members of the public may address the Boards orally and in writing. To provide Public Comment, you should visit https://lacera.com/leadership/board-meetings and complete the request form.

If you select oral comment, we will contact you via email with information and instructions as to how to access the meeting as a speaker. You will have up to 3 minutes to address the Boards. Oral comment requests will be accepted up to the close of the Public Comment item on the agenda.

If you select written comment, please input your written public comment within the form as soon as possible and up to the close of the meeting. Written comment will be made part of the official record of the meeting. If you would like to remain anonymous at the meeting without stating your name, please leave the name field blank in the request form.

9:05 a.m. **Welcome**
Luis A. Lugo, Deputy Chief Executive Officer

9:10 a.m. **Healthcare Landscape: Federal Legislation**
Presented by: Segal Consulting
Speakers: Amy Dunn, Vice President and Senior Consultant, Segal, Health Compliance Practice

Amy Dunn will provide an update regarding federal legislation affecting retiree healthcare programs.

9:45 a.m. **Healthcare Landscape: Medical and Prescription Drug Plan Trend Highlights**
Presented by: Segal Consulting
Speakers: Deborah Donaldson, Senior Vice President and West Region Health Practice Leader; Daljit Johl, PharmD, Vice President and Pharmacy Benefits Consultant

Deborah Donaldson and Daljit Johl will share medical and prescription drug plan highlights from the 2025 Segal Health Plan Cost Trend Survey, with an emphasis on retiree healthcare plans. This is Segal's 28th annual survey of managed care organizations, health insurers, Pharmacy Benefit Managers, and Third-Party Administrators, which collectively represent more

than 80 percent of the commercially insured and self-insured market.

10:45 a.m. **Break**

11:00 a.m. **AccordantCare – Supporting Patients with Complex, Rare Health Conditions**
Presented by: CVS Health
Speaker: Lynne Chilton, Clinical Advisor Supervisor

AccordantCare is the Disease Management program affiliated with CVS Health pharmacy benefit paired with the LACERA-administered Anthem Blue Cross I, II, and III Plans. It is a comprehensive patient care program that has been providing whole-person care, including comorbidity management, to patients with complex and rare health conditions for more than 20 years. This program utilizes real-time pharmacy and medical claims data, electronic health records, and health plan and specialty pharmacy referrals to identify plan members with complex conditions earlier. AccordantCare nurses proactively provide support to better manage the whole condition through evidence-based interventions.

12:00 p.m. **Lunch**

1:00 p.m. **Retiree Healthcare Overview**
Presented by: Retiree Healthcare Division
Speakers: Tionna Fredericks, Sr. Retirement Benefits Specialist, and Letha Williams-Martin, Retirement Benefits Specialist III

The Team will provide a comprehensive overview of the Retiree Healthcare Program, including the program history, Medicare basics and Part B premium reimbursement as well as planned service enhancements to ensure a superior member experience.

2:00 p.m. **Break**

2:15 p.m. **Retiree Healthcare Plan: Rights and Obligations Under 1982 Agreement**
Presented by: Legal and Retiree Healthcare Division
Speakers: Jean Kim, Senior Benefits Counsel, Cassandra Smith, Director of Retiree Healthcare, and Leilani Ignacio, Assistant Division Manager, Retiree Healthcare

The Team will provide an overview of the legal rights and obligations of LACERA and LA County with respect to the Retiree Healthcare Benefits Program arising from the 1982 Agreement and its subsequent amendments.

3:15 p.m. **Closing Remarks & Good of the Order**

Documents subject to public disclosure that relate to an agenda item for an open session of the Board of Retirement and Board of Investments that are distributed to members of the Boards less than 72 hours prior to the meeting will be available for public inspection at the time they are distributed to a majority of the Board Trustees at LACERA's offices at 300 N. Lake Avenue, Suite 820, Pasadena, CA 91101, during normal business hours of 9:00 a.m. to 5:00 p.m. Monday through Friday.

Requests for reasonable modification or accommodation of the telephone public access and Public Comments procedures stated in this agenda from individuals with disabilities, consistent with the Americans with Disabilities Act of 1990, may call the Board Offices at (626) 564-6000, Ext. 4401/4402 from 8:30 a.m. to 5:00 p.m. Monday through Friday or email PublicComment@lacera.com, but no later than 48 hours prior to the time the meeting is to commence.

LACERA Board of Retirement Offsite:
Empowering Success Through Shared Action

Healthcare Landscape: Federal Legislation

May 20-21, 2025

Amy Dunn, JD, Vice President, and Senior Consultant, Segal, Health Compliance Practice

Segal

Agenda

Executive Action

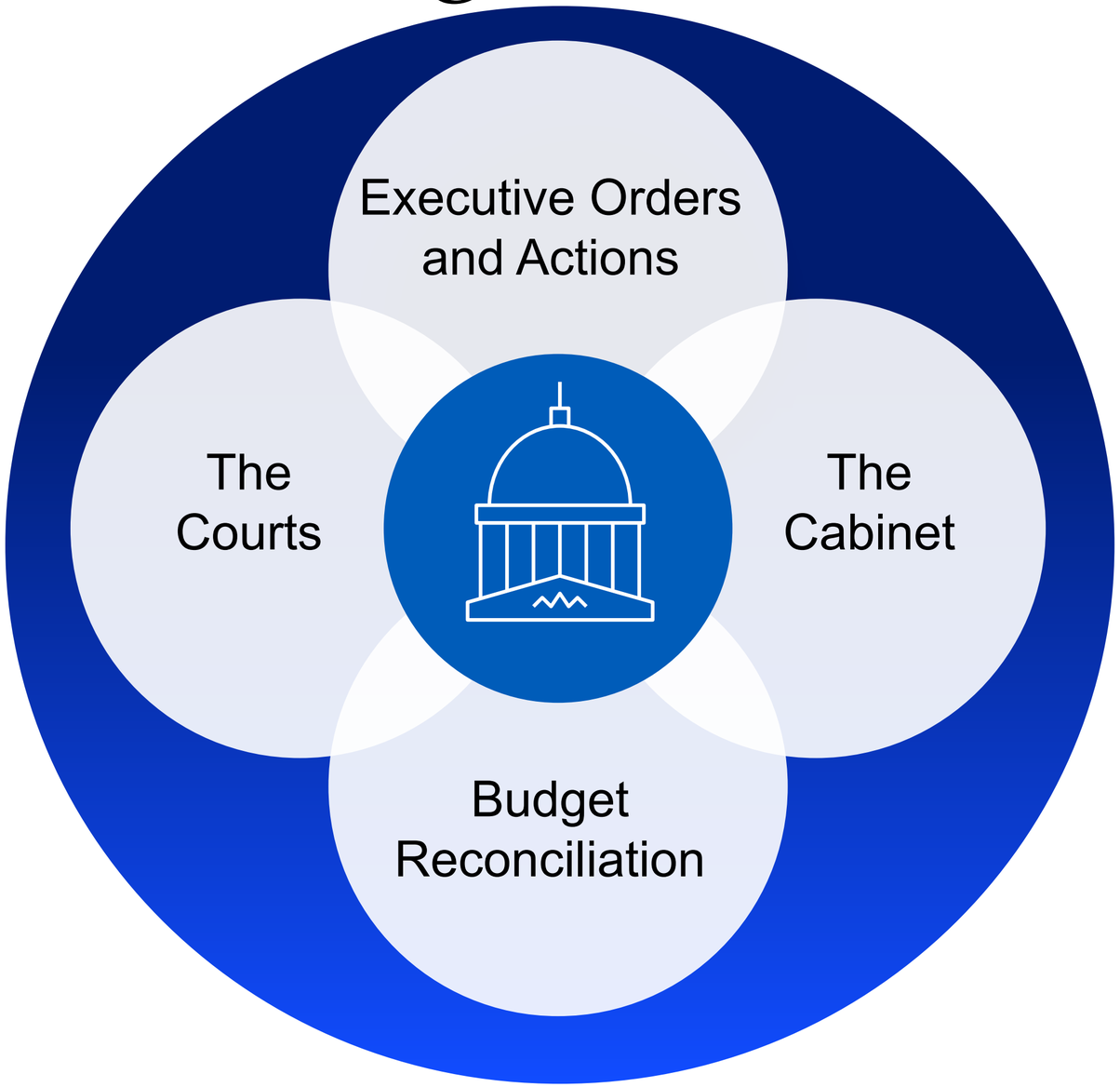
More on Pharmaceuticals

Taxes, Spending, and the Budget

Medicare Part D and Medicare Advantage

Executive Action

What We're Watching



Executive Orders that May Impact Group Health Plans

Directing the Repeal of Unlawful Regulations

- April 9, 2025, Memo to Agencies directing them to repeal unlawful regulations
- Directs Agencies to review recent US Supreme Court cases and repeal rules immediately without notice and comment if possible
- First regulations likely to be repealed are those no longer applicable
  - E.g., Treasury has repealed two notices issued implementing the ACA Tax on High-Cost Plans, which was repealed by Congress

Executive Orders that May Impact Group Health Plans

Lowering Drug Prices by Once Again Putting Americans First

- Drug Importation
- Address PBM Influences
- Medicare Drug Price Negotiations
- Medicare Part D
- Site-Neutral Payment Policies

More on pharmaceuticals…

Spotlight on Prescription Drugs

- Congress may continue its focus on the PBM industry, including increasing transparency and regulation of PBM arrangements
- Significant changes could include requiring PBMs to disclose rebate information and pass through 100 percent of rebates and ban spread pricing, requirements for plan sponsors to ensure that PBM contracts contain certain disclosure requirements

Possibility of Tariffs on Pharmaceuticals

- Pharmaceuticals were exempt in the April 2, 2025, executive order issued on reciprocal tariffs; however, . . .
- On April 16, 2025, the administration announced that the Commerce Department would commence a national security investigation of imports of pharmaceuticals and pharmaceutical ingredients under Section 232 of the Trade Expansion Act
- This investigation could lead to tariffs in the sector, which could impact drug prices and availability

Taxing, Spending, and the Budget

Expiration of the 2017 Tax Cuts

Tax policy is Congress's top priority because of the expiration of the tax cuts in the 2017 Tax Cuts and Jobs Act

- Congress seeking tax reform through the budget reconciliation process – but reconciliation can only address tax, spending, and budget items
- Debt limit and disaster aid are also part of the discussions

House and Senate Passed Budget Resolution

- The House voted on April 10, 2025, to adopt a Senate-passed budget resolution that would:
  - Provide over $5 trillion to extend tax cuts
  - Authorize military and border security spending
  - Increase the debt ceiling by $5 trillion
  - Cut at least $1.5 trillion in spending
  - Uses “current policy baseline” that assumes tax cuts do not count as increased spending
  - The House budget plan instructions to its committees still apply:
    - Energy and Commerce committee, which overseas Medicare, Medicaid, and the ACA instructed to come up with at least $880 billion in cuts

Reconciliation Timing

- Reconciliation bills are reported to the budget committee
- House leadership would like to get a bill to the floor by mid-May
- Could go to conference committee
- Potential for action in late summer

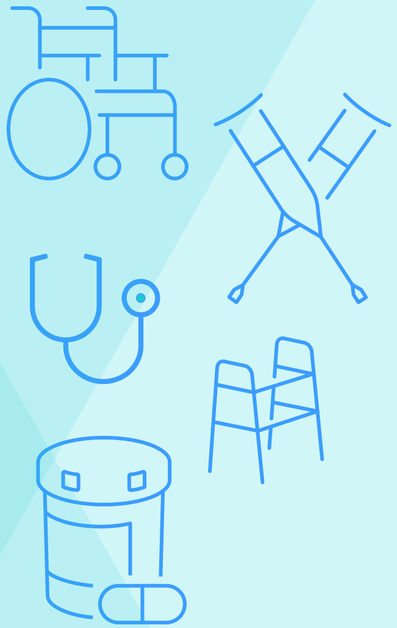
Medicare Part D and Medicare Advantage

Inflation Reduction Act

The Inflation Reduction Act has resulted in a significant restructuring of the Medicare Part D prescription drug benefit, including a $2,000 out-of-pocket maximum ($2,100 for 2026)

- Guidelines for 2026 Part D plans were finalized in April 2025

Part D Coverage



It will be important to examine how the new administration addresses the expansion in Part D benefits and continues efforts to ensure that Part D premiums remain affordable

- In July 2024, CMS announced a “premium stabilization demonstration” for Part D, which should cover at least three years. The 2026 financial subsidy has not yet been announced, but some commenters are criticizing the program as too costly ($5 billion in 2025 alone)

Medicare Advantage, Rx Negotiation

- Similar challenges exist with respect to Medicare Advantage plans, which are popular options.
  - Revisions to reimbursement requirements are possible.
- Proposals have included making Medicare Advantage a default enrollment option for Medicare beneficiaries or increasing opportunities for plans to offer supplemental benefits.
- Additionally, for the first time in 2026, Medicare will negotiate prices for certain high-cost drugs.
  - The next set of 15 drugs was announced January 17, 2025, and includes Ozempic, Rybelsus, Wegovy
  - While the program may not be significantly changed for the first year, the new administration's policy priorities will likely impact the process for future years.

Thank You

Amy Dunn, JD
Vice President, Senior Consultant,
Health Compliance
adunn@segalco.com
818-956-6704

Segal

Amy Dunn, JD

Vice President, Senior Consultant, Health Compliance

Expertise

Amy is a Vice President and Senior Consultant in the Health Compliance practice based in Segal's Glendale office. She has more than 20 years of compliance consulting experience, navigating federal, state and local health and welfare laws and regulations, including the Affordable Care Act, HIPAA, COBRA, USERRA, wellness plans and IRC section 125 plans.

Professional background

Prior to joining Segal, Amy was Principal/Growth Leader in Buck's Compliance Consulting practice for more than eight years. She worked with public sector, corporate and multiemployer clients in a wide range of industries. She prepared plan documents, assisted with responses to the IRS and HHS, and designed and conducted employee training on compliance topics. Earlier in her career, Amy was a compliance consultant at Mercer.

Amy Dunn, JD

Vice President, Senior Consultant, Health Compliance

Education/professional designations

Amy earned a JD from Whittier Law School (Costa Mesa, CA). She holds a Masters in Health Administration and a BA in Organizational Leadership from Chapman University (Orange, CA). Amy previously was on the faculty of the University of Phoenix's College of Health Professions, where she was named Faculty Member of the Year in 2019.

Publications/speeches

Amy is a frequent speaker at seminars and conferences, including the National Business Group on Health, the Western Pension & Benefits Conference, the International Society of Certified Employee Benefit Specialists and the SouthWest Benefit Association.

LACERA Board of Retirement Offsite:

Empowering Success Through Shared Action

Healthcare Landscape: Medical and Prescription Drug Plan Trend Highlights

May 20-21, 2025 / Deborah Donaldson, FSA, MAAA / Daljit Johl, PharmD

Segal

Agenda

Results of 2025 *Segal Health Plan Cost Trend Survey*

What's Behind the Numbers

What Drives Trend?

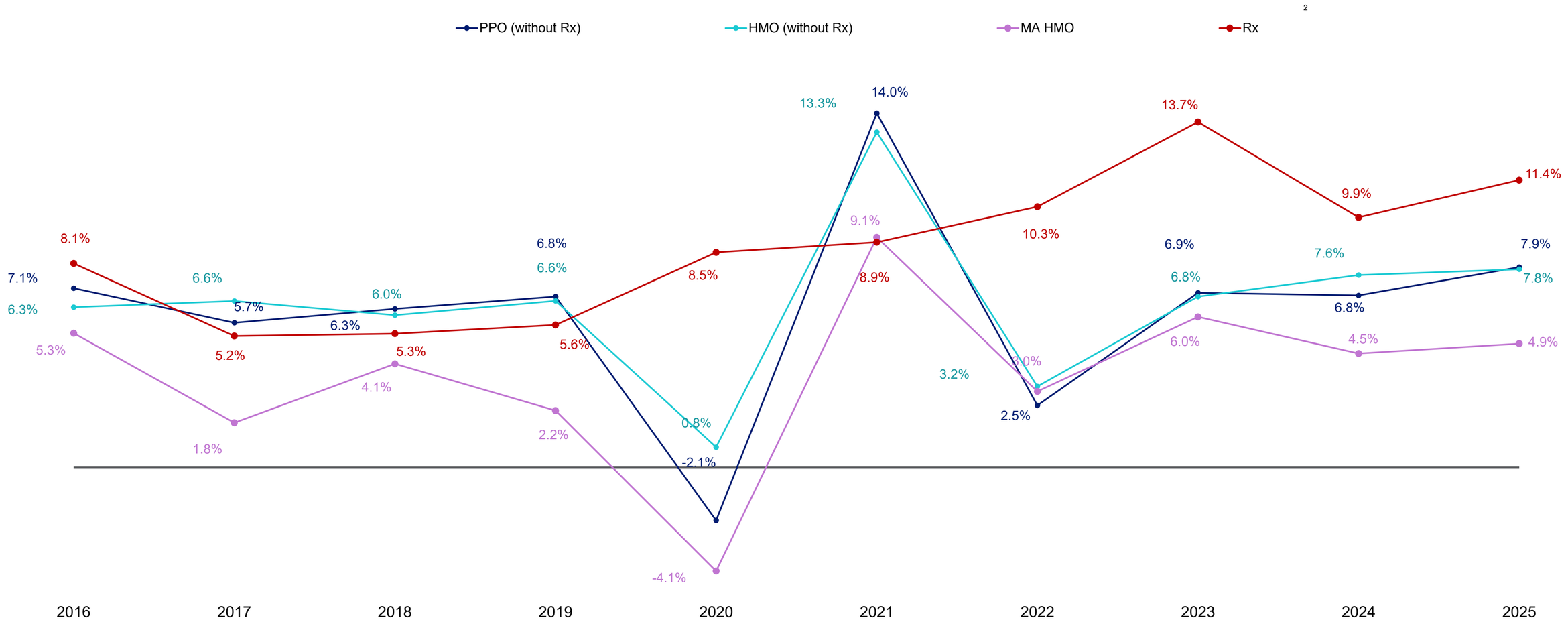
Top Five Cost-Management Strategies

Top Medical Cost Management Strategies

Top Rx Cost Management Strategies

Questions?

Ten-Year Summary of Selected Medical and Rx Trends: *2016–2023 Actual and 2024 and 2025 Projected*[1]



Source: 2025 *Segal Health Plan Cost Trend Survey*

[1] All trends are illustrated for actives and non-Medicare retirees, except for MA HMOs.

[2] Prescription drug trend is combined for retail and mail order delivery channels.

What's Behind the Numbers

1. The 2025 projected annual cost trend for Rx is 11.4%, the highest rate of all health benefit cost trend estimates. Rx is driven by new costly therapies, including:
   - GLP-1 class of medications used for diabetes and weight-loss
   - Cancer drugs, including new therapies for advanced cancers
   - Expanded disease indications (such as Dupixent®), increasing utilization

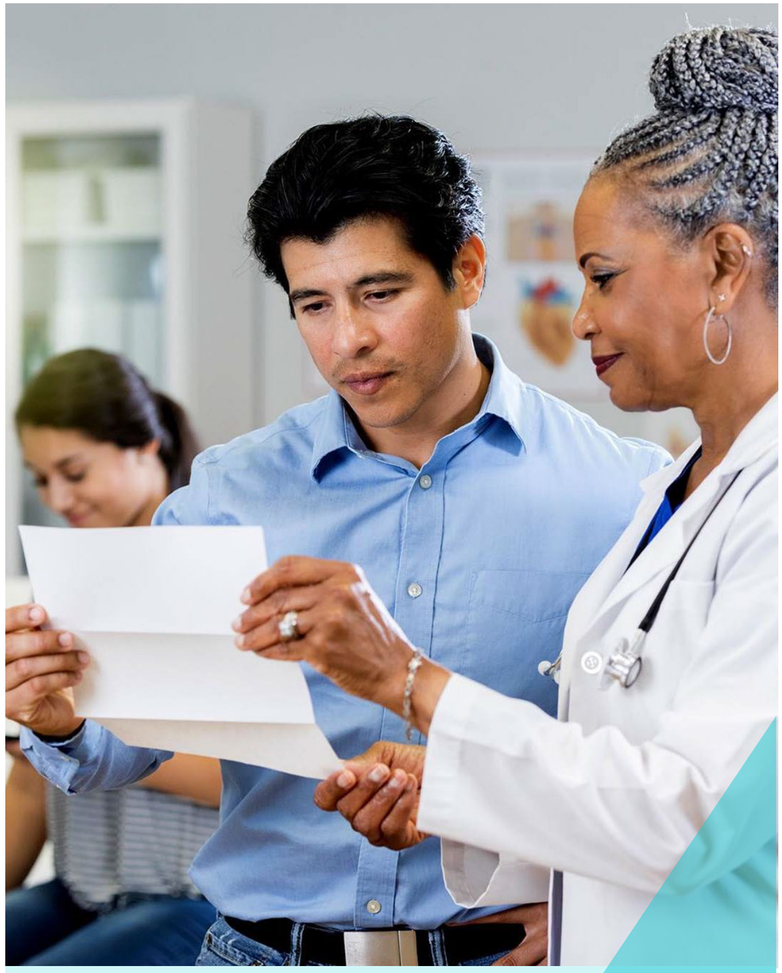
2. Actual prescription drug cost trends continue to be in the double digits, at 13.7% as reported by carriers and PBMs. SHAPE data shows 11.3% as of December 2023

3. Rx plan cost trend are almost 5% higher in 2023 for plans that cover GLP1s for weight loss than those that don't
   - 13.2% trend when coverage includes anti-obesity medications (AOMs) vs. 8.4% when coverage excludes AOMs

4. Specialty drug cost trend remains in the double-digits, driven by:
   - Utilization changes, accounting for almost 60 percent of the gross cost trend increase before rebates
   - High list price increases

What's Behind the Numbers

1. Projected 2025 PPO plan trends are one percentage point higher.
   - The forecasted median plan cost increases for 2025 are at levels of 8%
2. Medical price inflation: In mid-2024, medical unit cost price inflation increased and exceeds growth of prices for non-medical goods and services.
   - Inflationary pressures have led to higher contracted reimbursement rates
3. Hospital unit cost is the largest component of 2025 medical trends.
   - As hospital prices increase, there continues to be a shift of care to outpatient due to improved technologies
4. Outpatient total trends were highest in 2023 of all settings at 8.7%. Outpatient costs were mainly driven by higher acuity utilization including:
   - Cancer-related testing and treatment
   - Surgeries for osteoarthritis and spinal disorders
   - Increased utilization of the emergency room

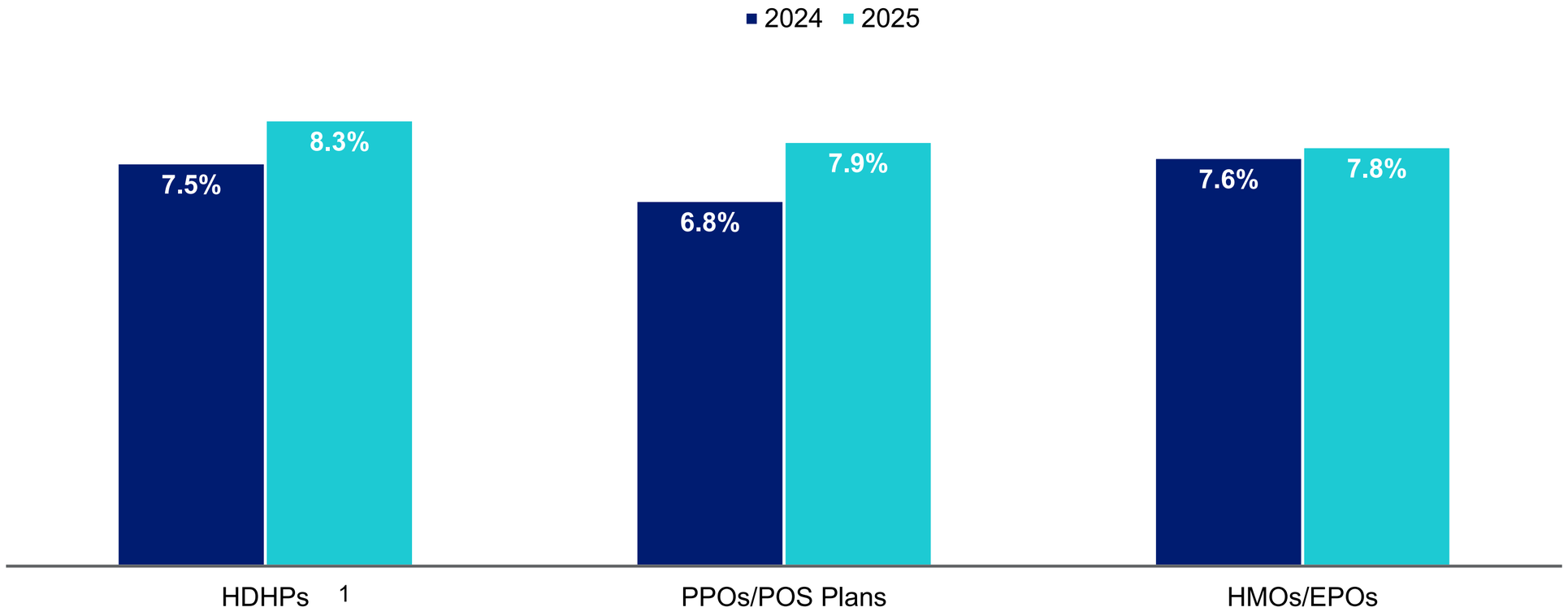


What Drives Trend?

- Medical inflation, impacting the cost of care delivery
- New treatments, therapies and technology
- Increased treatment burden due to the aging population and rise in obesity
- Expanded disease indications for existing therapies
- Fee for Service Payment System
- Greater emphasis on detection and diagnostics
- Defensive medicine (e.g., excessive testing)
- Health Provider consolidation
- Provider cost shifting from reduced payment by Medicare and Medicaid
- Regulatory changes
- Social and economic factors, which can influence utilization or care decisions
- Erosion effect of fixed deductibles and copayments[1]

[1] This is a driver of net paid claim cost trends, not gross per capita claims cost increases.

Projected Medical Trends for Actives and Non-Medicare Retirees: 2024 and 2025

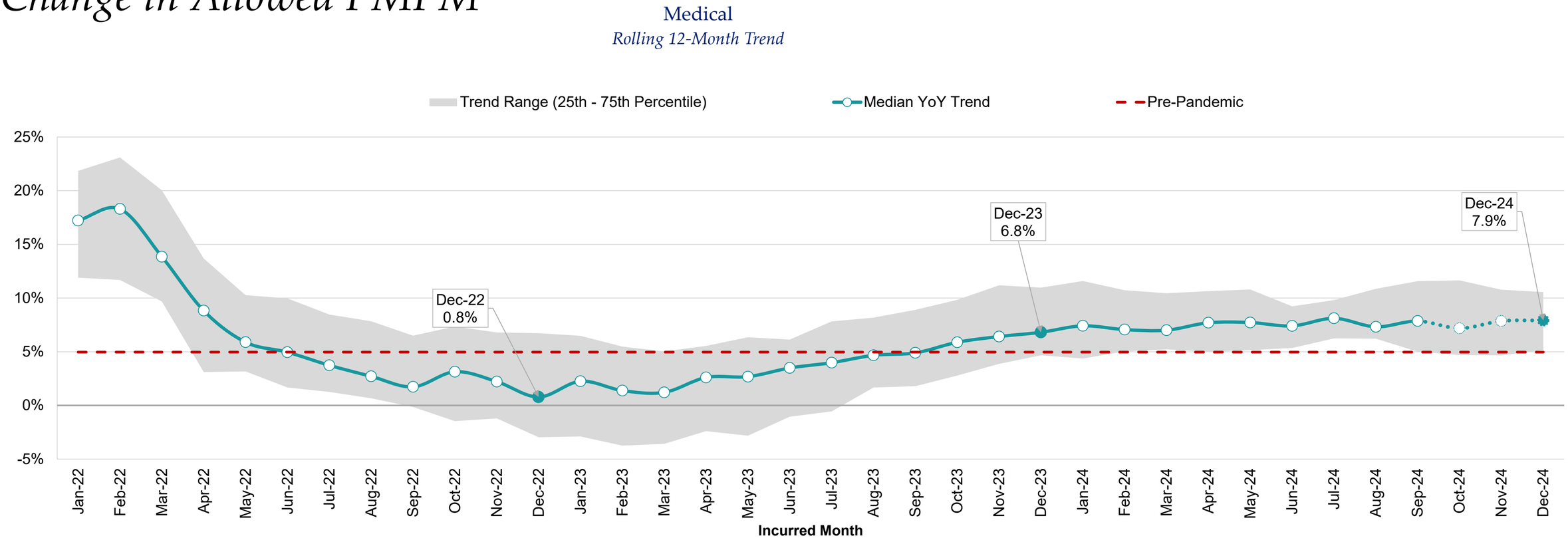


Source: 2025 *Segal Health Plan Cost Trend Survey*

[1] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of healthcare services.

Medical Trend Summary

% Change in Allowed PMPM

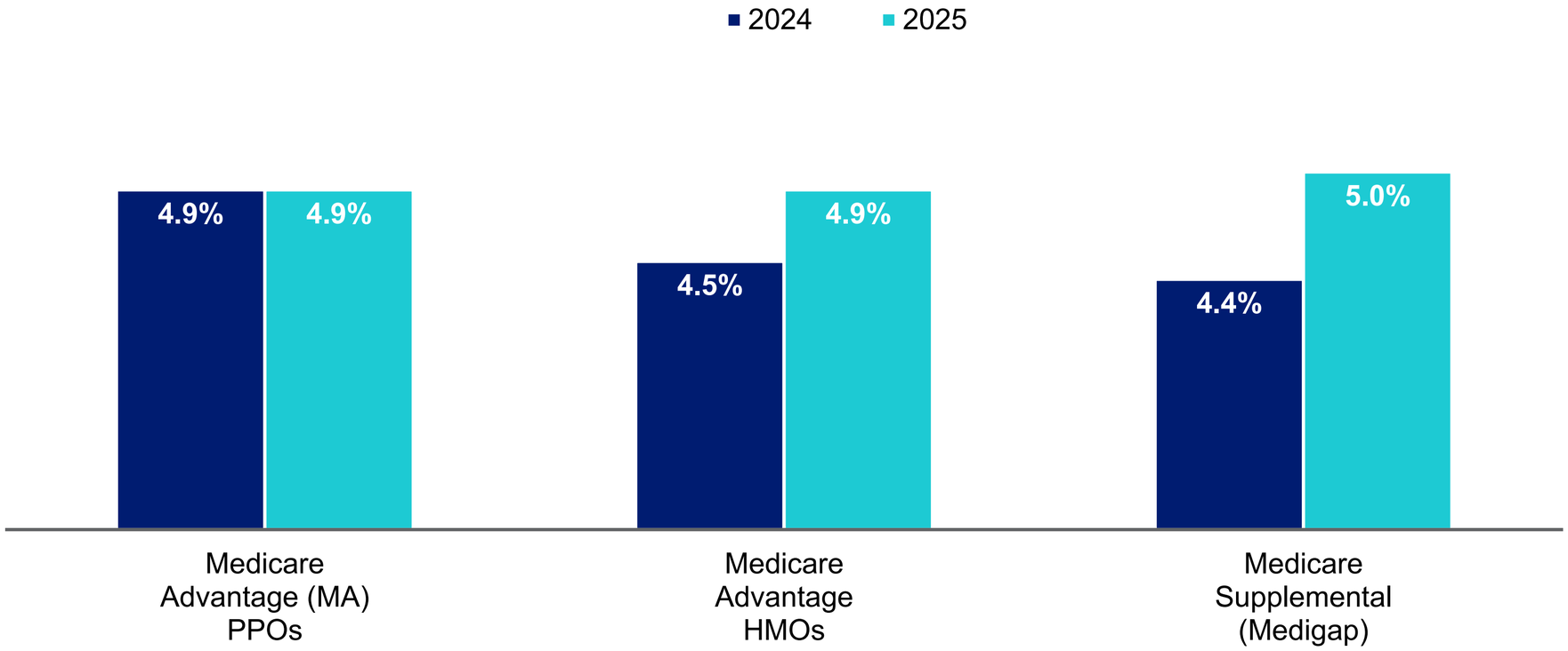


Source: SHAPE Data Warehouse

Note: Pre-pandemic trend represents the year-over-year trend rate from CY 2018 to CY 2019.

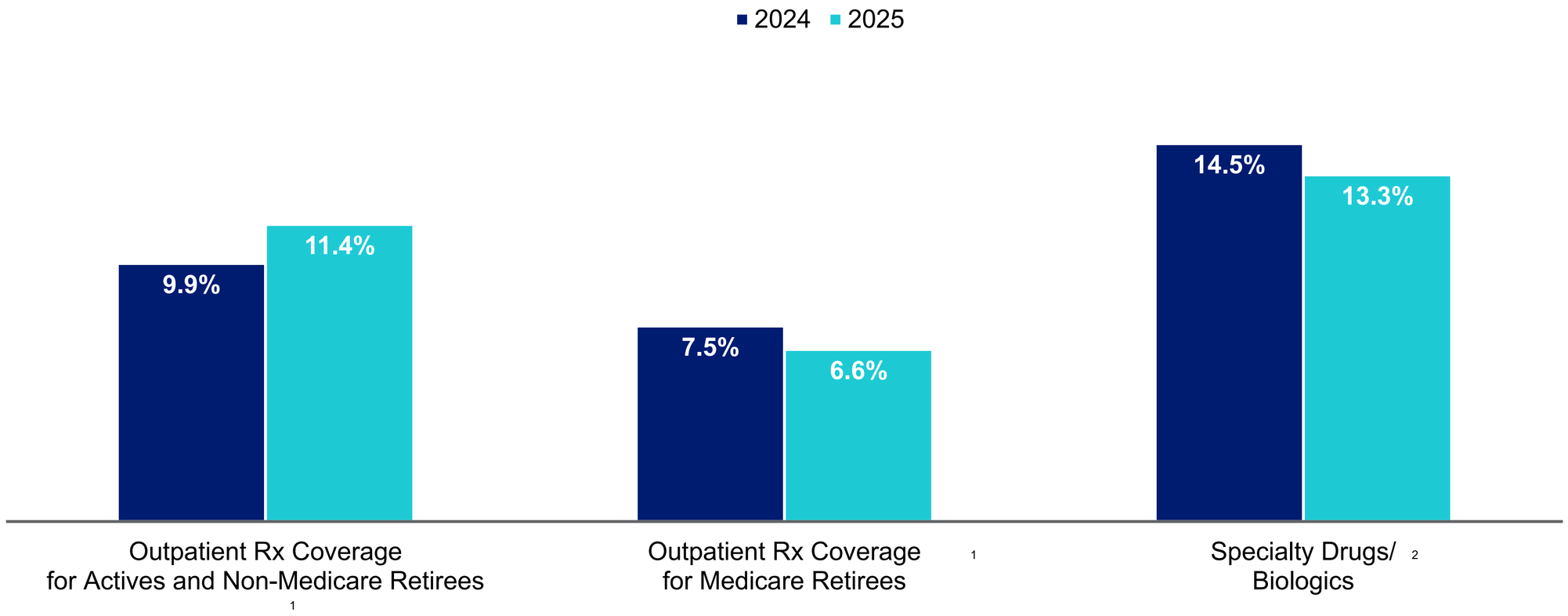
Dotted line represents months where at least 30% of claims have not been paid yet and are estimated.

Projected Medical Trends for Medicare Retirees: 2024 and 2025



Source: 2025 *Segal Health Plan Cost Trend Survey*

Projected Prescription Drug Trends: 2024 and 2025



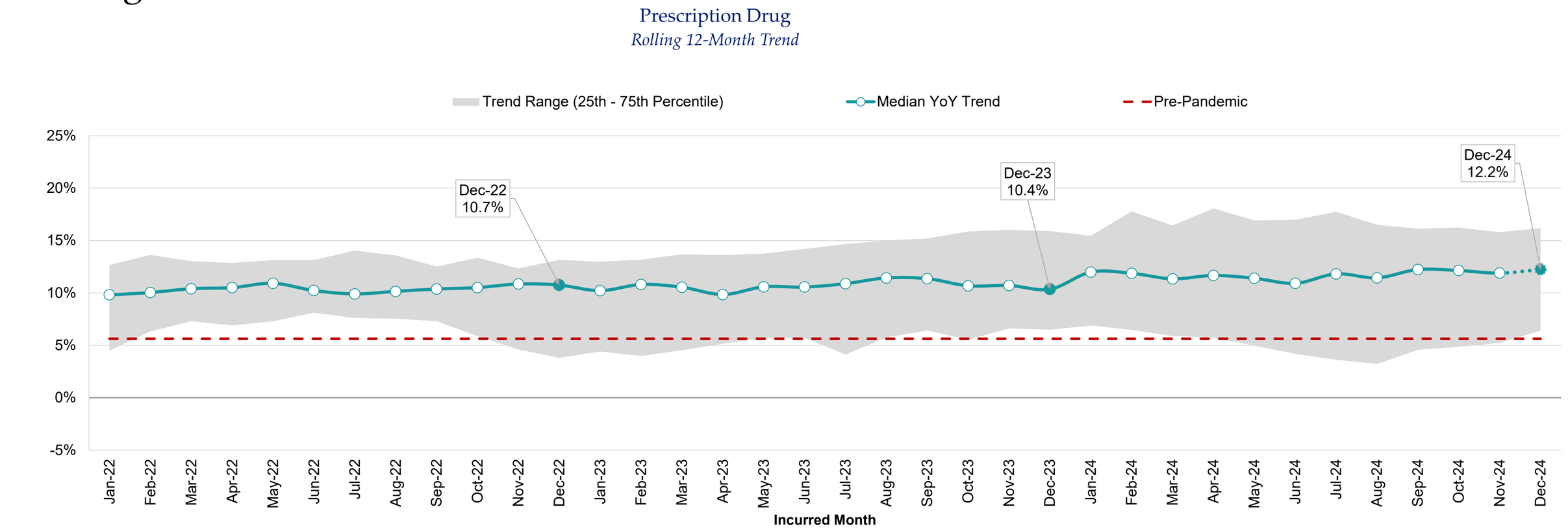
Source: 2025 *Segal Health Plan Cost Trend Survey*

[1] Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer sponsored plans before PBM rebates.

[2] Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for participants of all ages.

Prescription Drug Trend Summary

% Change in Allowed PMPM



Source: SHAPE Data Warehouse

Note: Pre-pandemic trend represents the year-over-year trend rate from CY 2018 to CY 2019.

Dotted line represents months where at least 30% of claims have not been paid yet and are estimated.

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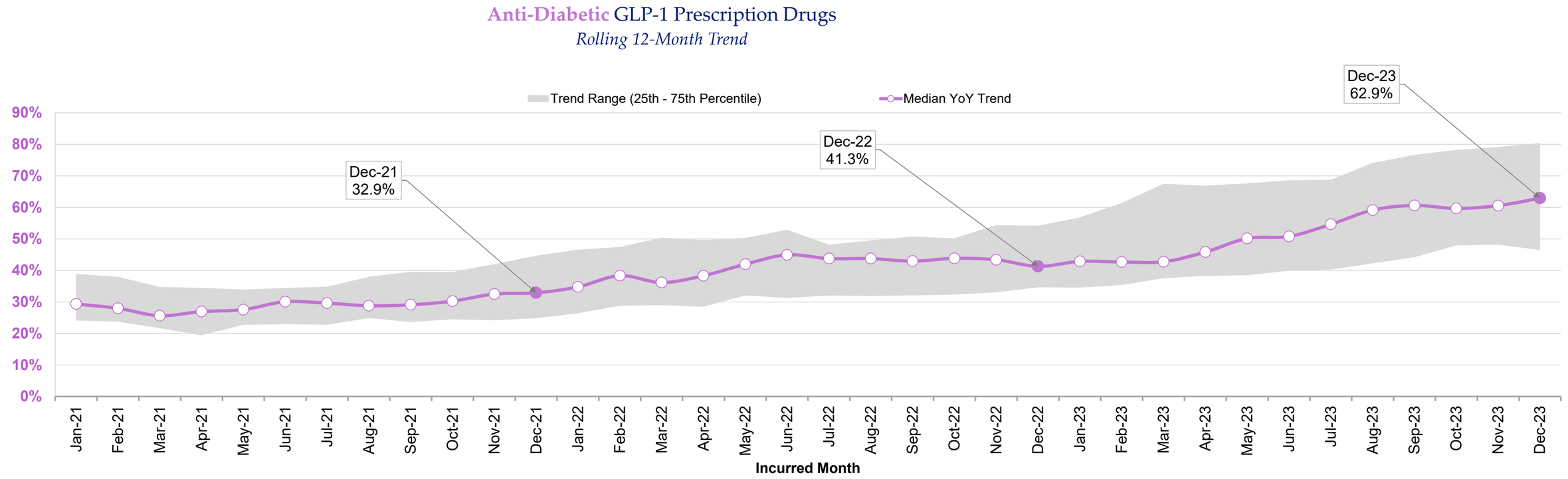
Prescription Drug Trend Summary – GLP -1s

% Change in Allowed PMPM for Anti-Diabetic Agents

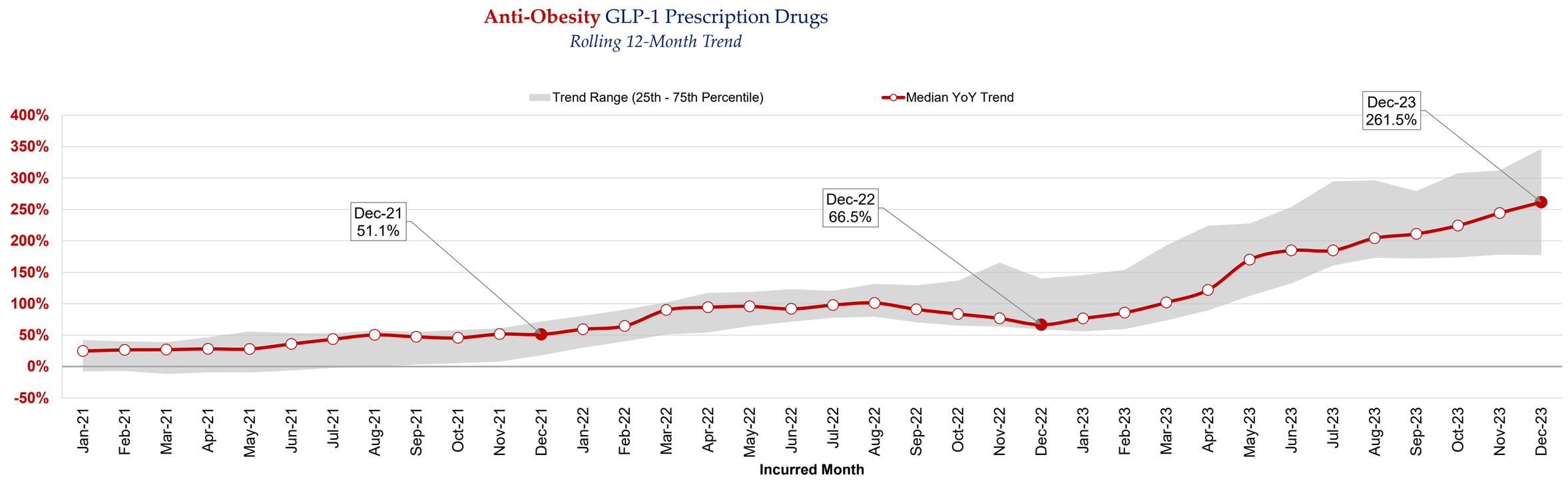


Source: SHAPE Data Warehouse

Segal

Prescription Drug Trend Summary – GLP -1s

% Change in Allowed PMPM for Anti-Obesity Agents

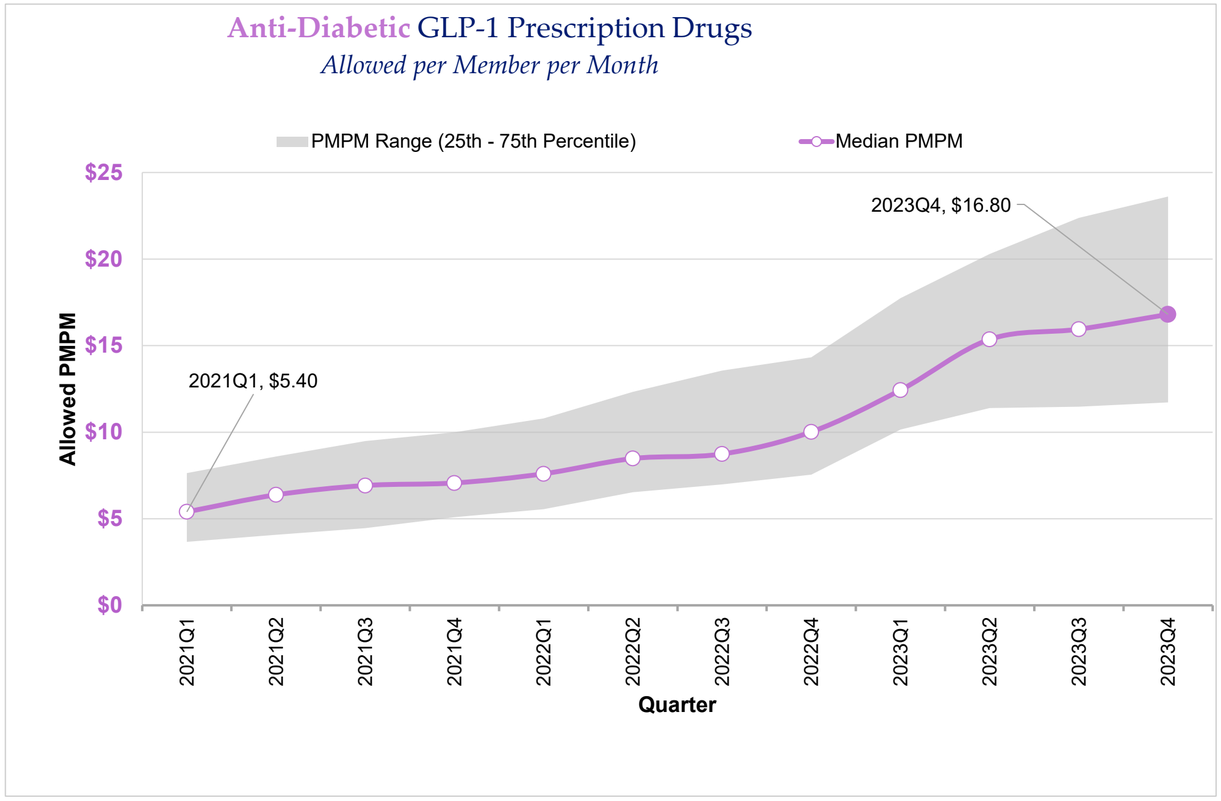


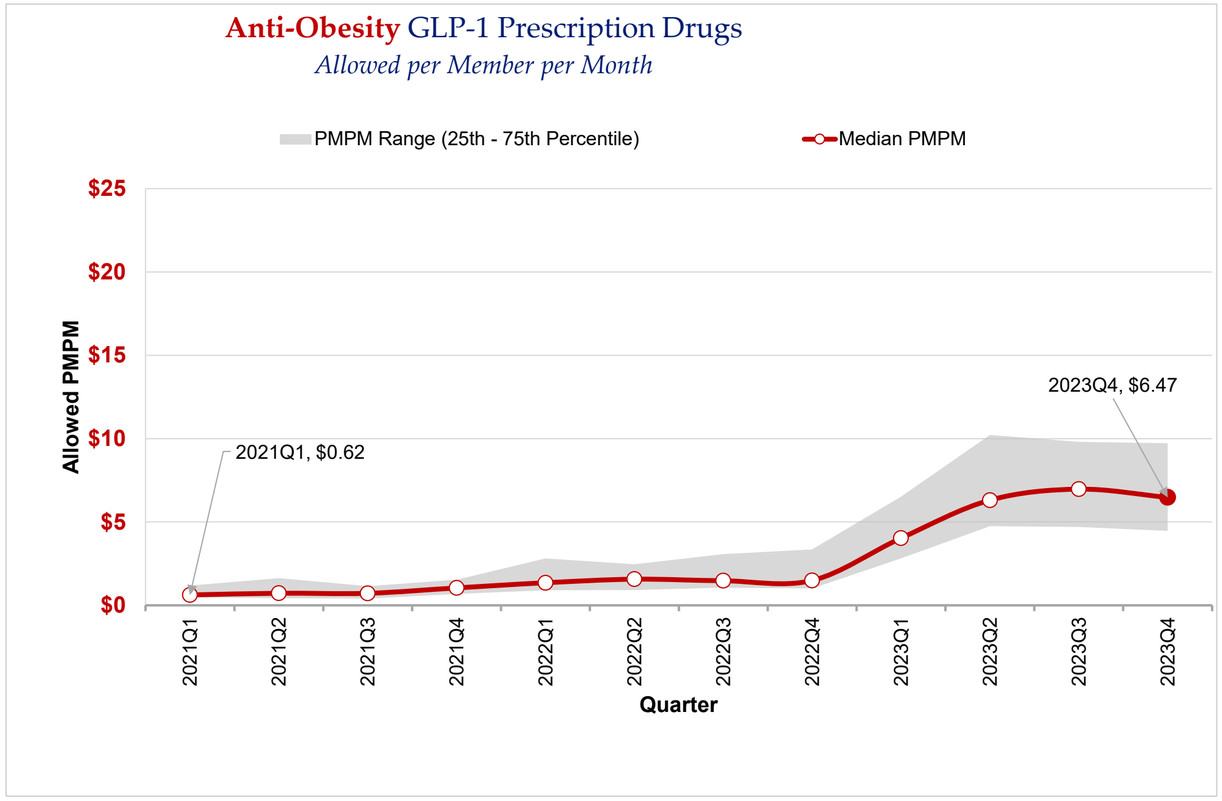
Source: SHAPE Data Warehouse

Segal

Prescription Drug Trend Summary – GLP -1s

Allowed PMPM by Disease Indication





Source: SHAPE Data Warehouse

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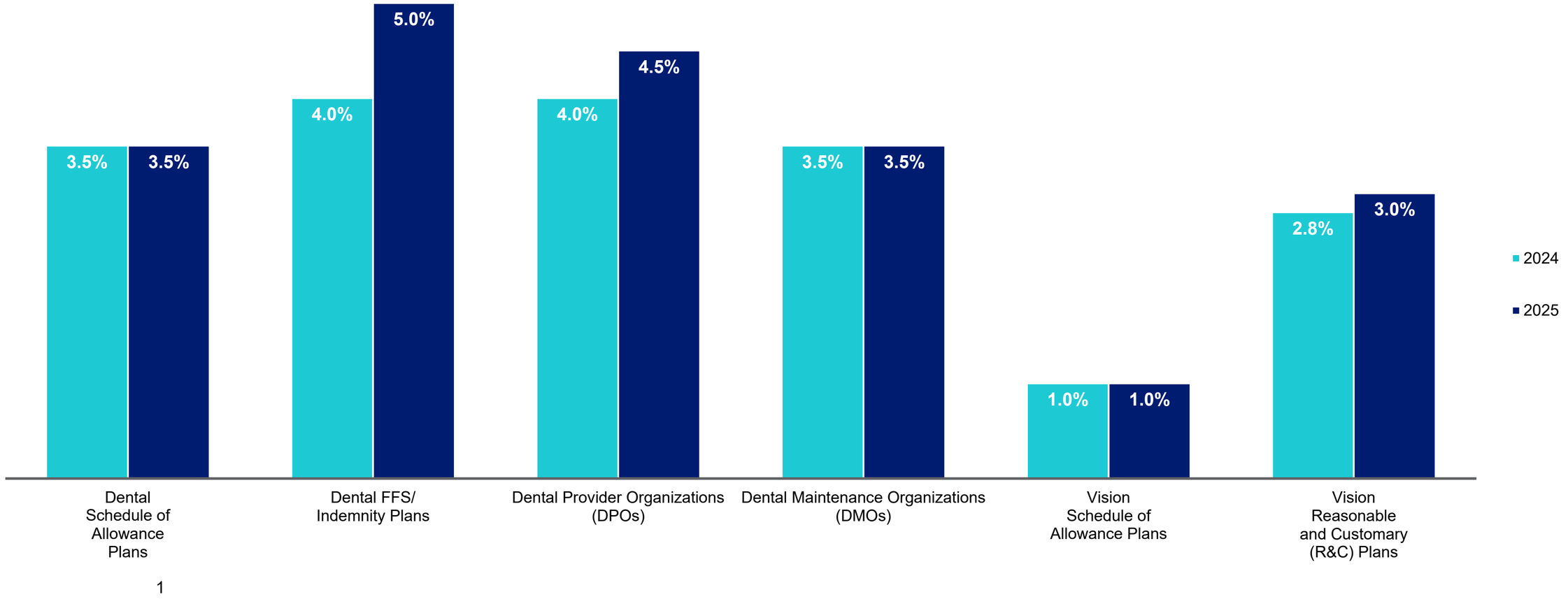
Projected Dental and Vision Trends: 2024 and 2025



Source: 2025 *Segal Health Plan Cost Trend Survey*

[1] A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan.

Top 5 Cost-Management Strategies: 2024

Survey participants were asked to rank the top cost-management strategies implemented in 2024.

Cost Management Strategy

1. Implement strategies to address anti-diabetic GLP-1 medications (e.g., quantity limits, step therapies, preauthorization)
2. Implement strategies to address anti-obesity medications for GLP-1 coverage (e.g., limits, step therapies, lifestyle modification)
3. Control specialty drug mix through use of biosimilar strategies (e.g., lowest net cost, mandatory biosimilars for new patients)
4. Adopt custom or narrow drug formulary
5. Implement digital health coaching for behavioral health issues, diabetes, hypertension, etc.

Plan sponsors continue to implement various cost management strategies to help mitigate increasing health plan costs while maintaining high quality access to care.

Top Medical Cost Management Strategies

3. Data Analytics

Plan sponsors should consider drawing on their own data to make well-informed decisions about which strategies and services produce the most value, especially given their limited resources.

- Performing data analytics to identify cost drivers, what providers and treatments produce the best value, identify areas of plan waste and inefficiencies and evaluate the performance of programs.
- Focus on design and strategies that are most appropriate for the plan's population.

One cannot manage what cannot be measured.

Top Medical Cost Management Strategies

4. Cancer Treatment and Prevention

For most plan sponsors, oncology is now the number one disease category in terms of health cost spending. Explore best practice approaches with existing carriers:

Prevention

- Provide FDA-approved and CDC-recommended vaccines for the prevention of cancer
- Educate employees about cancer risk factors and health promotion activities to reduce cancer risk
- Share healthy living resources including info on nutrition
- Provide tobacco/vape cessation support
- Offer mental well-being programs

Detection

- Educate employees about recommended screening options
- Add incentives for evidence-based cancer screening exams (breast, cervical, & colorectal)
- Expand coverage to include additional screening (lung, prostate, skin, etc.)
- Offer programs, services, or policies to facilitate screening
- Measure screening rates and other health indicators

Diagnosis

- Provide opportunities for expert second opinion services
- Offer coverage for approved genetic testing and counseling
- Offer treatment decision support
- Consider a high-quality Center of Excellence network with strategic benefit design

Treatment

- UM guidelines based on NCCN criteria
- Clinical care mgmt. with SDOH support & BH management
- Add pharmacy site of care steerage program
- Cancer nutrition counseling with a Registered Dietitian
- Consider low touch / virtual model for lower stage uncomplicated cases, with focus on social & BH needs
- Add coverage for off-label use of biologics and biosimilars

Survivorship & End of Life

- Simplify hospice coverage to support end of life planning
- Add coverage for fertility preservation
- Financial planning and support services
- Cancer-specific BH/MH services
- Add lifestyle services that provide access to wigs, cosmetics, clothing etc. to support quality of life
- Peer-to-peer support services to connect with others on the cancer journey

Caregiver Support

- Offer workplace accommodations (e.g., flexible schedules, telecommuting, etc.)
- Return-to-work planning support
- Education on rights and leave policies
- Proactive screening to identify vulnerable caregivers; connect them with community-based resources

Top Medical Cost Management Strategies

6. Revisit Plan Design

Revisit your plan design cost sharing dynamics. Good plan design that offers member copay savings when lower cost sites of service or setting are used have shown to work for plan sponsors.

- Does the plan create the proper incentive to use lower cost urgent care centers before emergency rooms, or primary care doctors before specialists' visits?
- Does the plan design incent savings for using biosimilars when appropriate?
- Does the plan encourage step therapy by establishing attractive coverage for less intensive (and costly) treatments such as physical therapy vs surgery, outpatient behavioral health vs inpatient services?

Top Medical Cost Management Strategies

7. Enhance Behavioral Health

Behavioral health solutions, including digital health solutions that treat mental health conditions and/or substance use have proliferated in recent years as technology has evolved and venture-capital backing has grown.

When evaluating behavioral health solutions for your organization, consider these five areas:

1. Needs and Access – use your claims data to assess needs
2. Organizational Readiness – determine if your organization is ready for new behavioral health solutions
3. Vendor Quality – identify high quality vendors
4. Awareness – for behavioral health solutions to be effective, participants first need to understand why the solutions can help
5. How to monitor and measure results – To measure results, consider creating a pre- and post-program dashboard of outcomes

Top Rx Cost Management Strategies

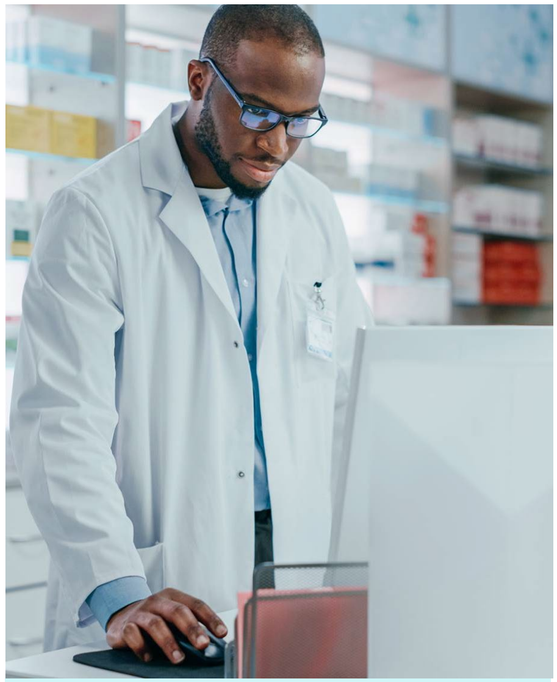
1. **Plan Benefit Design**

   Effective plan design strategies offer low-cost sharing for lower-cost generic drug therapies and higher cost sharing for more costly brand drugs, where interchangeable or lower-cost alternative therapies exist.

2. **PBM Contract Review**

   Plan sponsors need to recognize their buying power. By understanding the best prices available in the market and the true breakeven operating expenses of PBMs and retail pharmacies, plan sponsors can trade market share for better pricing in contracts and cut out much of excess margins retained by the intermediaries (e.g., PBMs, retail pharmacies and mail-order pharmacies).

Top Rx Cost Management Strategies



3. **Limited Use of Formulary Management**

   Often, drugs placed on or removed from formularies have to do with PBMs gaining profit, not a plan sponsor's best interest.

   - Plan sponsors should consider more effective, limited formularies that can deliver significant plan savings with no negative impact on patient care

4. **Apply Effective Clinical Controls**

   Plan sponsors should test the PBM's clinical systems and staff and only use the programs that will work for the plan.

   - In some cases, utilization management programs, like prior authorization and step therapy, are useful tools to produce plan cost savings.
   - In other cases, clinical programs that support participants who have complex needs and conditions may not save on the prescription drug claim costs but can avoid costly medical plan claims and complications

Top Rx Cost Management Strategies

5. Promotion of Biosimilars

- A tiered plan design that offers lower member costs when taking biosimilars
- Updated formularies that include biosimilars as the preferred option
- Utilize prior authorization that directs providers and members towards biosimilars if available and appropriate
- Facilitate biosimilar adoption by covering interchangeable biosimilars, which, like generic drugs, can be converted to from originator biologics without requiring prescriber authorization
- Implement step therapy so members start with lower cost biosimilars before becoming eligible for more expensive originator biologics
- Consider uptiering or exclusion of coverage for the originator product
- Cap reimbursement based on the lowest cost biosimilar (or percentage above the lowest cost biosimilar and the billed biosimilar)
- Reduce or implement $0 cost-share for members when a biosimilar is used (or incentivize with a member or provider with reward when biosimilars are utilized)
- Contract with a vendor to manage utilization and direct to biosimilars
- Provide education and outreach to members to inform them about the availability of biosimilars, the associated cost savings, and their efficacy compared to the originator product

Segal

Thank You

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Deborah Donaldson, FSA, MAAA

Senior Vice President, West Region Health Practice Leader, Denver

Expertise

Debbie is a Senior Vice President and Benefits Consultant, affiliated with the Denver office. She is Segal's West Region Health Practice Leader, with more than 20 years of technical and employee benefits consulting experience as an actuary and consultant in both the public and private sectors. She has consulted with clients on strategic plan design and funding of benefit programs and has specialized expertise in retiree benefit programs, notably pre-65 and Medicare Advantage plans.

Debbie's experience includes all aspects of employee benefit programs, including vendor selection and management, financial management and reporting (such as rate development, budget projections and reserving), wellness, ancillary benefit programs and alternative service models. She has depth of experience working with states and public sector entities and has presented various topics to boards and legislature bodies.

Segal

Deborah Donaldson, FSA, MAAA

Senior Vice President, West Region Health Practice Leader, Denver

Professional background

Prior to joining Segal, Debbie was Actuarial Director at UnitedHealthcare Retiree Solutions, where she led a Strategic Growth, Reporting and Analytics team responsible for client reporting and financial presentations, analytics and strategic initiatives and a multi-disciplinary team that developed a pre-65 retiree healthcare solution..

Before she joined UnitedHealthcare, Debbie was the Denver Health & Benefits Practice Leader at Willis of Colorado, Inc. and a Vice President at Aon, where she was the Lead Consultant for a number of state health plans.

Education/professional designations

Debbie received a BS in Actuarial Sciences from the University of Illinois Urbana-Champaign (Champaign, IL). She is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. She has participated in several community service programs.

Publications/speeches

Debbie led the analysis for a publication on the impact of high-risk medications for Medicare Advantage members. In addition, she has presented at State and Local Government Benefits Association (SALGBA) meetings as well as other government bodies on benefit topics.

Daljit Johl, PharmD

Vice President and Pharmacy Benefits Consultant, San Francisco

Expertise

Daljit is a Vice President and Pharmacy Benefits Consultant in Segal's San Francisco office, supporting the West Region. She has more than 25 years of experience in pharmacy benefits. Daljit is a member of Segal's National Pharmacy Consulting Practice and assists clients in optimizing benefit design and formularies. She also serves as an expert in client management, strategic planning, PBM clinical programs, product and formulary strategies and analysis of prescription data. Daljit provides clinical consulting, analysis, support and strategic direction for clients nationally. She focuses on assisting Segal clients in vendor selection and implementation, contract negotiation and clinical program development.

Professional background

Prior to joining Segal, Daljit served as a Clinical Program Manager for a PBM, where she used her clinical expertise to develop strategies for employers to optimize their prescription drug benefits. Prior to that, she worked as a benefits specialist at Blue Shield of California. Daljit also worked as a manager at Statscript pharmacy, specializing in drug management and education in the HIV community.

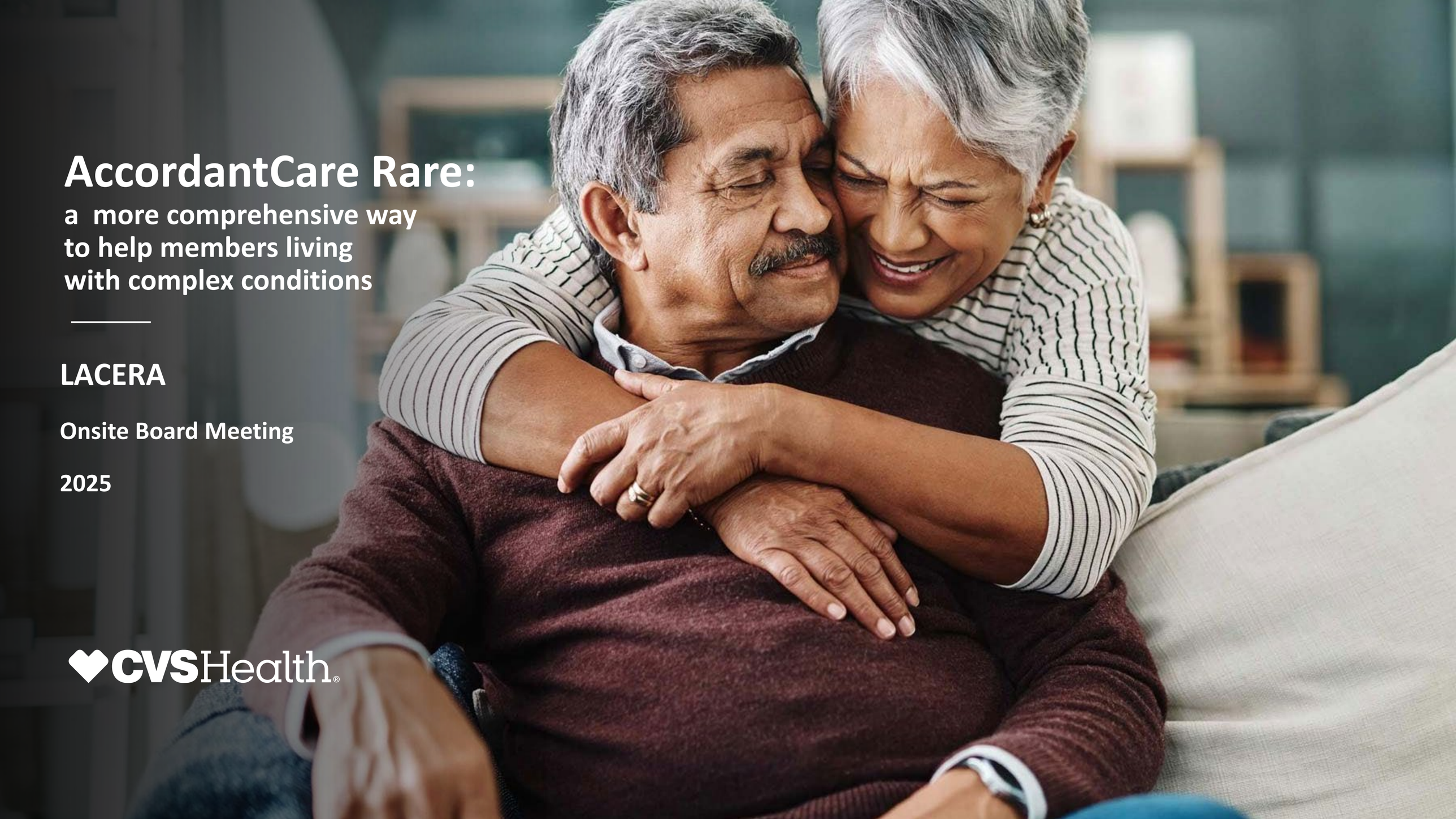
Segal

Daljit Johl, PharmD

Vice President and Pharmacy Benefits Consultant, San Francisco

Education/professional designations

Daljit holds a Doctor of Pharmacy degree from the University of California, San Francisco, and a BS in Biology from California State University (Chico, CA). She is a registered Pharmacist and an active member of the Academy of Managed Care Pharmacy (AMCP).



AccordantCare Rare:

a more comprehensive way to help members living with complex conditions

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LACERA

Onsite Board Meeting

2025

CVSHealth®

Agenda

AccordantCare Program Overview

AccordantCare Rare Program Nurse Support

Rare Care Management Member Journey

LACERA Member Engagement

AccordantCare Program Updates- Preventative Health Webinar

LACERA Care Solution support- Medical Cost Avoidance

Delivering proactive, whole-person support that enhances patient care while reducing health care costs

Rare condition experience and expertise

300+ nurse-clinicians licensed in 50 states

Medical Advisory Board of 30+ physicians

Deep domain knowledge

Integrated with rare disease understanding

Disease-specific model supports comprehensive care

Engaging members

Proactive 1:1 connections empower members to improve health and manage complex needs

Connecting member care

Real-time information for informed, coordinated care with convenient mobile and online member access

Helping to optimize medical and pharmacy spend

Encouraging healthier member choices helps improve health, lower costs

---

NCQA accreditation in Population Health and Case Management

120K

Members benefitted from Accordant nurse-led care management last year

20

Rare and complex conditions managed through AccordantCare Rare

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Transforming care management through digital engagement and empowerment tools

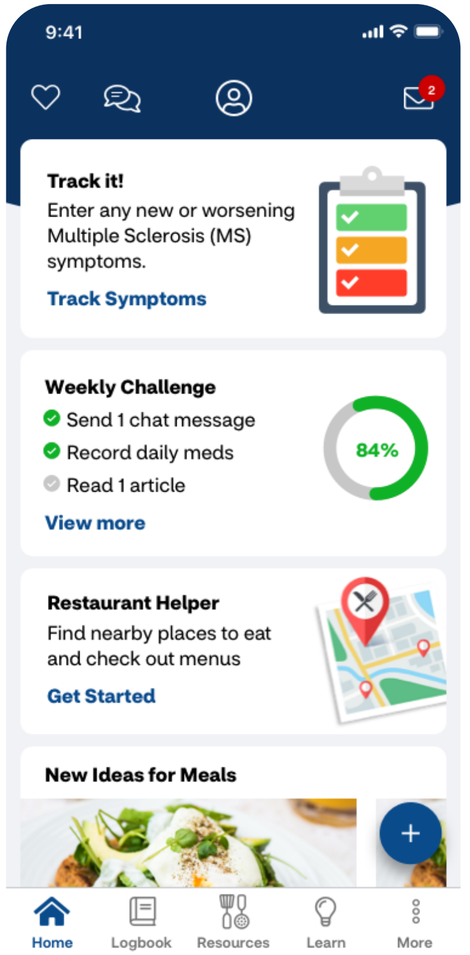
Health Optimizer
helps to connect your members with care

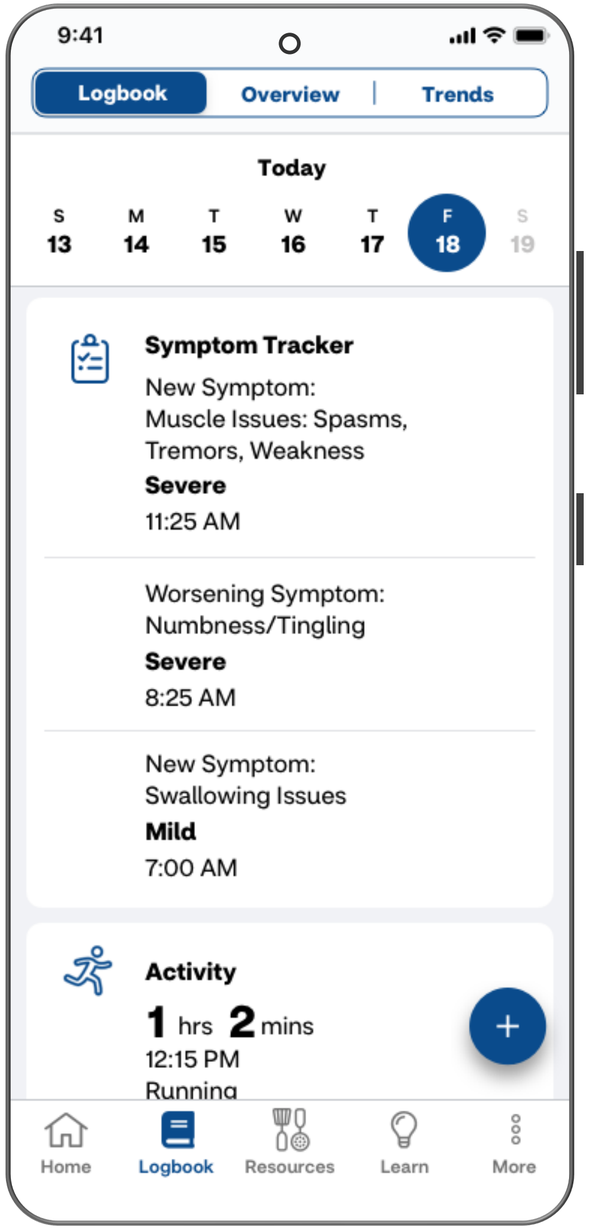
Intuitive app that is easy to use

Supports proactive CareTeam* connections

Empowers participant self-management

Sustains continuous engagement



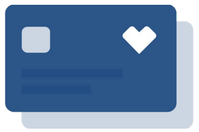


*Accordant Care Team ("CareTeam").

CVS Health

Care, Especially For Complex Members, Is Not One Size Fits All

Accordant takes a holistic and individualized approach to managing the health of members at both the individual and population level through assessment of Social Determinants of Health-related barriers to care in six domains informed by Kaiser Family Foundation's ongoing health equity work.



Economic Stability

- Employment
- Income
- Expenses
- Medical bills

Neighborhood & Physical Environment

- Housing
- Transportation
- Safety
- Zip code/geography

Food

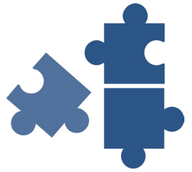
- Hunger

Health Care System

- Health coverage
- Provider availability
- Provider linguistic and cultural competency

Community & Social Context

- Social integration
- Support systems
- Community engagement



Education

- Literacy
- Language
- Higher Education

Member care journey

Meet Ruth

Ruth is a 63-year-old woman living with Rheumatoid Arthritis. She was also diagnosed with Hypertension and Osteoporosis. Struggling with pain management, Ruth was taking large amounts of Tylenol and Naproxen daily.

In her first meeting with her dedicated nurse, Ruth receives a personal care plan and an introduction to MyChart.

Ruth receives education on safe medication dosages, Rheumatoid Arthritis management and risk for flares, and support in keeping a pain diary.

To help Ruth deal with stress, her nurse stages a proactive behavioral intervention using her IMB skills framework training.

Her dedicated nurse leads her Accordant care team support. When complex issues arise, she consults with the Accordant medical advisory board.

Her nurse arranges a meeting with an Accordant Resource Specialist who helped Ruth find financial support and transportation to and from doctor visits.

AccordantCare provides 1:1, whole-person care.

Ruth is now able to follow her individualized care plan, manage her specific symptoms, reduce her financial stress, improve her psychosocial needs and stay on track with her medication.

IMB (information-motivation-behavioral).

AccordantCare Rare
LACERA Member Engagement

Monthly Participation Summary- Engaged

March 2025

LACERA

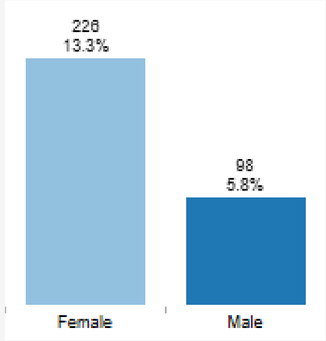
Engaged Population

324
19.0%

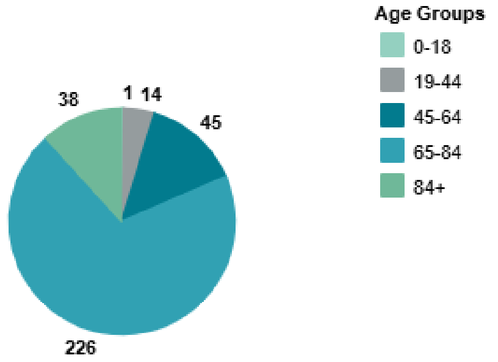
Reporting Status

Interactive	Self-Directed
242	82
14.2%	4.8%

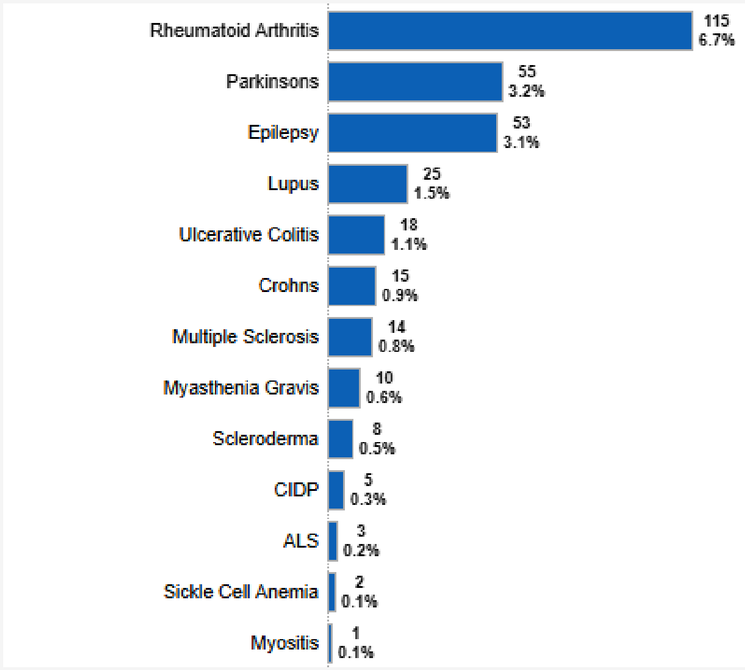
By Gender



By Age Groups



By Condition



Distribution in the engaged member population is primarily concentrated to 5 rare conditions:

- Rheumatoid Arthritis
- Parkinson’s
- Epilepsy
- Lupus
- Ulcerative Colitis

Monthly Participation Summary- Eligible, Not Yet Engaged

March 2025

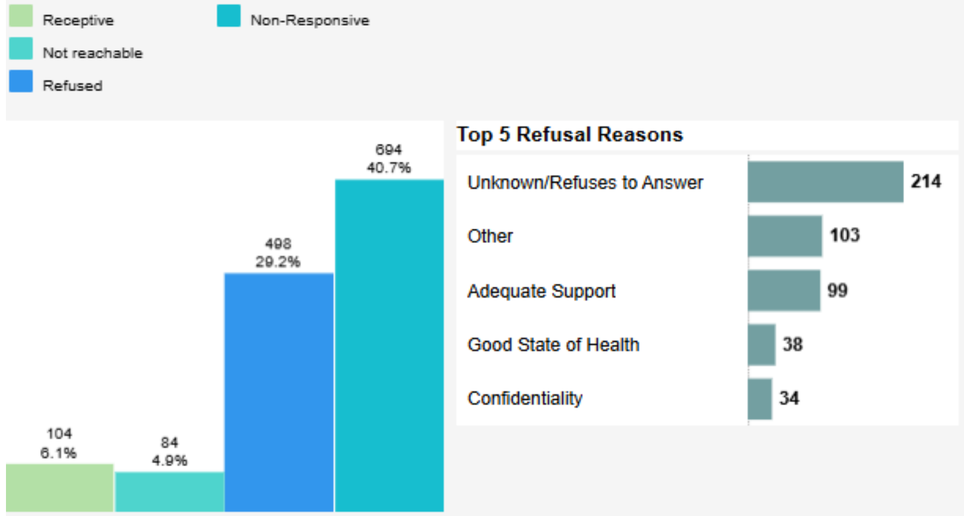
AccordantCare Rare

LACERA

Eligible, Not Engaged Population

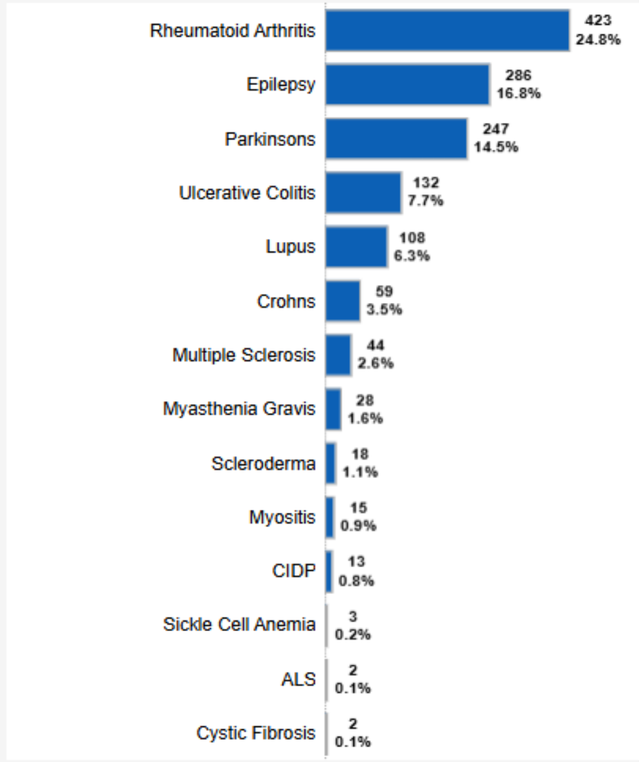
1,380
81.0%

Reporting Status

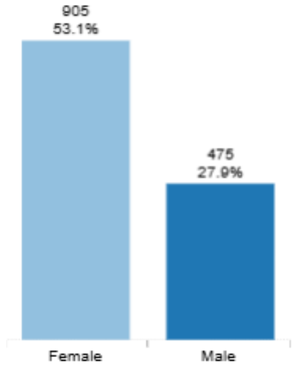


Top 5 Refusal Reasons

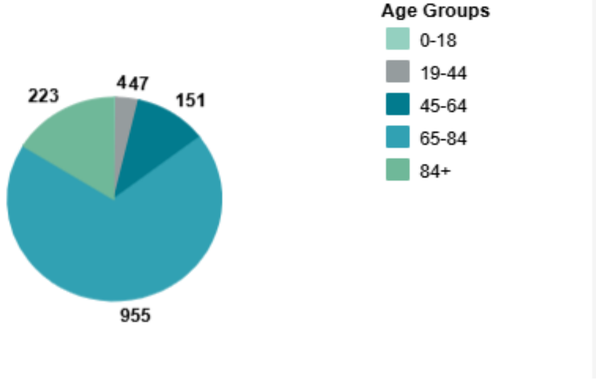
By Condition



By Gender



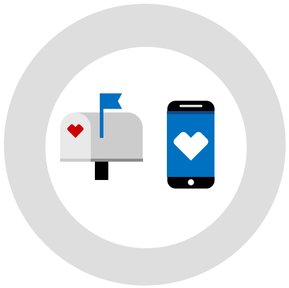
By Age Groups



- Proactive outreach to all eligible LACERA members identified, not solely the most acute
- Eligible members receive a welcome letter and an Accordant introductory welcome kit highlighting program description alongside receiving telephonic outreach
- Accordant Engagement Associates take lead with telephonic outreach, and are skilled at highlighting the benefits of the program, and comprehensive whole person support
- Telephonic outreach and member communications encourage engagement for members managing complex and rare conditions

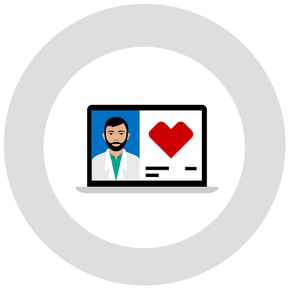
Getting members involved

in any way they choose to participate



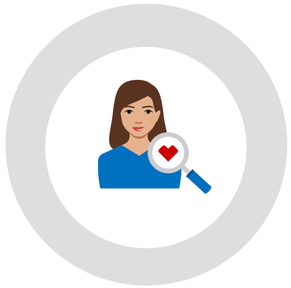
First contact

By welcome letter, then members choose email, text, phone or online updates



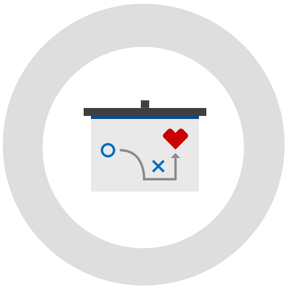
Participation options

Interactive calls with a dedicated Accordant nurse, or self-directed care using digital channels



Best practices

Dedicated Accordant nurse model utilizes behavioral interviewing techniques and includes outreach to all identified, not just the most acute



Integration

Using data to identify members and conduct outreach earlier

Thank you

Appendix

What is the AccordantCare Program?

The AccordantCare program is designed to help members find the answers ar support they need to manage their health care needs and maximize their ove health status. This specialized education and support program is offered to members with the following conditions:

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic Kidney Disease (CKD)
- CIDP (Chronic Inflammatory Demyelinating Polyradiculoneuropathy)
- Crohn’s Disease
- Cystic Fibrosis
- Dermatomyositis
- Epilepsy (Seizures)
- Gaucher Disease
- Hemophilia
- Hereditary Angioedema (HAE)
- Human Immunodeficiency Virus (HIV)
- Multiple Sclerosis
- Myasthenia Gravis
- Parkinson’s Disease
- Polymyositis
- Rheumatoid Arthritis
- Scleroderma
- Sickle Cell Disease
- Systemic Lupus Erythematosus (SLE or Lupus)
- Ulcerative Colitis

AccordantCare Rare nurses and clinicians continuously enhance expertise that helps benefit members

Medical Advisory Board **LearningHub module** **Medical Advisory Board practicum** **Case deep dives**	Creating opportunities for staff to practice their skills and collaborate with each other, and education to continually enhance their clinical expertise.
Core education refresh	Evaluation of the education program for new colleagues with enhancements to approach, content and evaluation of effectiveness.
Care plan, risk prioritization review sessions	Sessions focus on enhancing individualized care plans including prioritization of assessment and identification of risk. Includes opportunities for nurses to review scenarios and complete care plans to demonstrate proficiency.
Information Motivation Behavior refresh training for all staff	Nurses practice and enhance their interaction skill set focusing on Information Motivation Behavior and recognizing when members are ready for change.
Engagement staff training and development	Core education training for new colleagues to provide a consistent approach to onboarding and evaluation of readiness to engage members.

Ways We Help Your Member Get The Support They Need

Our omnichannel approach improves, extends and amplifies personalized engagement
in ways members find easy and convenient

	Mychart	Mobile App	Email	Text
LACERA	**16%**	**66%**	**59%**	**34%**
Book of Business	10%	70%	54%	50%

Improving member health

Medical Cost Avoidance

LACERA

2025

Taking health plan outreach to the next level closes even more gaps in care,
resulting in higher member engagement, improved health outcomes and reduced medical costs

Comprehensive member view

Advanced predictive analytics use comprehensive member data to help identify and prioritize individualized opportunities

Prescription claims

Medical claims

Historical engagement

Demographics

Member-provided information

Individualized member care opportunities

Your members receive customized interventions across **four clinical impact areas**

Health screenings
Recommendations on preventive screenings to improve health outcomes and promote early detection

Health education
Education on preventing unnecessary hospital readmissions, reducing opioid abuse, and follow up after respiratory events

Vaccinations
Encourage members to follow up with their healthcare provider about important vaccines

Medication monitoring
Education on the importance of routine bloodwork while taking certain medications and opportunities to add or adjust medications

Personalized, proactive support

Only CVS Health can drive behavior change through a multi-channel approach that includes local, in-person touchpoints

CVS prescription bag messaging

Mail

Email

Text message

Member and provider follow-up promotes behavior change and gap closures

Vaccinations

HPV

Meningococcal

Health screenings

Breast cancer

Colorectal cancer

Lung cancer

Chronic kidney disease

Diabetic kidney monitoring

Obstructive sleep apnea

Health education

Endometriosis education

Hospital readmission prevention

Opioid abuse prevention

Respiratory follow-up

Medication monitoring

TSH monitoring

Add/Intensify treatment

Delivering outreach

using a multi-channel approach tailored to member preferences and behaviors

Digital: SMS
members receive texts (if opted in)

Digital: Email
members receive emails (if opted in)

Direct mail

HealthTag® Prescription **bag messaging**

Proactive outreach and interventions set members up for success

Bill is 49 years old.

He has COPD and high blood pressure and is overdue for his colonoscopy. He fills his prescriptions at his local CVS Pharmacy.

Medical claims

- Multiple hospitalizations in past two years related to COPD
- Overdue for colonoscopy

Pharmacy claims

- Fluticasone and vilanterol
- Losartan

Channel preference

- Direct mail
- Email
- SMS/Text

Geographic location

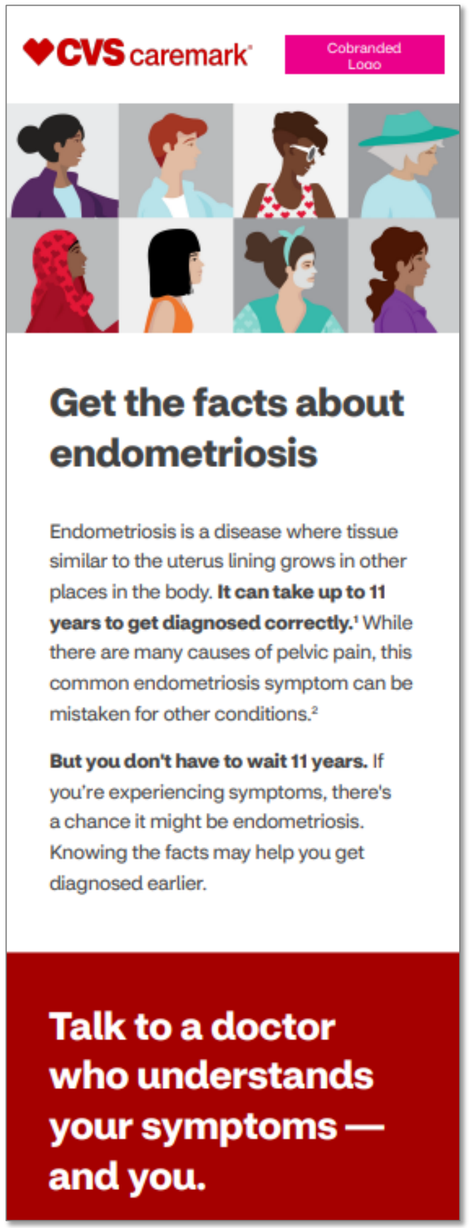
- High density for providers
- In-network labs
- 1.5 miles to a MinuteClinic

Bill receives a text message after recent hospital stay with education and strategies for preventing hospital readmissions.

Bill also receives email interventions educating him on the importance of getting his colonoscopy.

Channel permissions will be determined at the onset as part of our data request. Engagement feedback also informs channel preferences and targeting.

Sample Member Communications: Health Screenings




CVS Health

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The Maintenance Choice program is available to self-funded employer clients that are subject to ERISA. Non-ERISA plans such as fully insured health plans, plans for city, state or government employees and church plans need CVS Caremark legal approval prior to adopting the Maintenance Choice program. Prices may vary between mail service and CVS Pharmacy due to dispensing factors, such as applicable local or use taxes.

Specialty Expedite is available exclusively for providers who use compatible electronic health record (EHR) systems that participate in the Care quality Interoperability Framework.

Specialty delivery options are available where allowed by law. In-store pick up is currently not available in Oklahoma. Puerto Rico requires first-fill prescriptions to be transmitted directly to the dispensing specialty pharmacy. Products are dispensed by CVS Specialty and certain services are only accessed by calling CVS Specialty directly. Certain specialty medication may not qualify. Services are also available at Long's Drugs locations.

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LACERA
Los Angeles County Employees Retirement Association

Retiree Healthcare Overview

BOARD OF RETIREMENT OFFSITE

May 20-21, 2025
Day Two

How well do you know our retiree healthcare benefits program?

1. I could teach a class!
2. I know a thing or two.
3. Wait, what's that again?
4. I'm calling retiree healthcare.

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Los Angeles County Employees Retirement Association

Retiree Healthcare Benefits Program Overview

- LA County Plans vs LACERA's Retirement Plans
- Medical, Dental/Vision Plans
- Member/Dependent Eligibility
- Enrollment Process
- Premium Cost and Benchmark
- Tier 1 vs Tier 2
- Medicare Basics
- Medicare Part B Premium Reimbursement
- Strategic focus

LA County Active vs LACERA - Administered Retiree Healthcare Benefits Program

Los Angeles County Active Plans

- Annual Open enrollment
- Monthly benefits allowance
- Delta Dental plans
- More carrier options

Retiree Healthcare Plans

- No Open enrollment
- No Monthly Benefits allowance
- No Delta Dental plans
- Cigna dental/vision

LACERA
Los Angeles County Employees Retirement Association

Retiree Healthcare Benefits Program – Medical Plan Options

05

May 20-21, 2025

BOARD OF RETIREMENT OFFSITE

Medical Plans (Non-Medicare)

Indemnity (PPO) Plans

- Anthem I
- Anthem II
- Anthem Prudent Buyer

Health Maintenance Organizations (HMO) Plans

- Kaiser Permanente
- United Healthcare
- Cigna Network Model Plan

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Medicare Plans

(Medicare Parts A and B Required)

Medicare Supplement Plan

- Anthem III

Medicare Advantage Plans

- Kaiser Senior Advantage
- United Healthcare Medicare Advantage
- SCAN (CA, AZ, NV)*
- Cigna Medicare Select Rx plan (Arizona only) – closed July 1, 2025

**based on zip code*

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Los Angeles County Employees Retirement Association

Retiree Healthcare Benefits Program – Dental/Vision Plans

08

May 20-21, 2025

BOARD OF RETIREMENT OFFSITE

- Cigna Indemnity Dental/Vision
- Cigna HMO Dental/Vision

Retiree Healthcare Benefits Program – Member Eligibility

- **LACERA members who retire from:**
  - County of Los Angeles

- **Participating Agencies of the County:**
  - South Coast Air Quality Management District
  - Little Lake Cemetery District
  - Local Agency Formation Commission
  - Los Angeles County Office of Education
  - LACERA

LACERA
Los Angeles County Employees Retirement Association

Retiree Healthcare Benefits Program – Dependent Eligibility

May 20-21, 2025

BOARD OF RETIREMENT OFFSITE

11

Dependent Eligibility

- Lawful spouse unless legally separated
- Domestic Partner registered with the California Secretary of State
- Eligible dependent children:
  - Up to age 26 or
  - Disabled adult children that meet all handicap criteria
  - Legally adopted children

➢ Vital documents are required to add eligible dependents.
➢ Disabled verification is required to add disabled adult children.

LACERA
Los Angeles County Employees Retirement Association

Retiree Healthcare Benefits Program – Enrollment Process

13

May 20-21, 2025

BOARD OF RETIREMENT OFFSITE

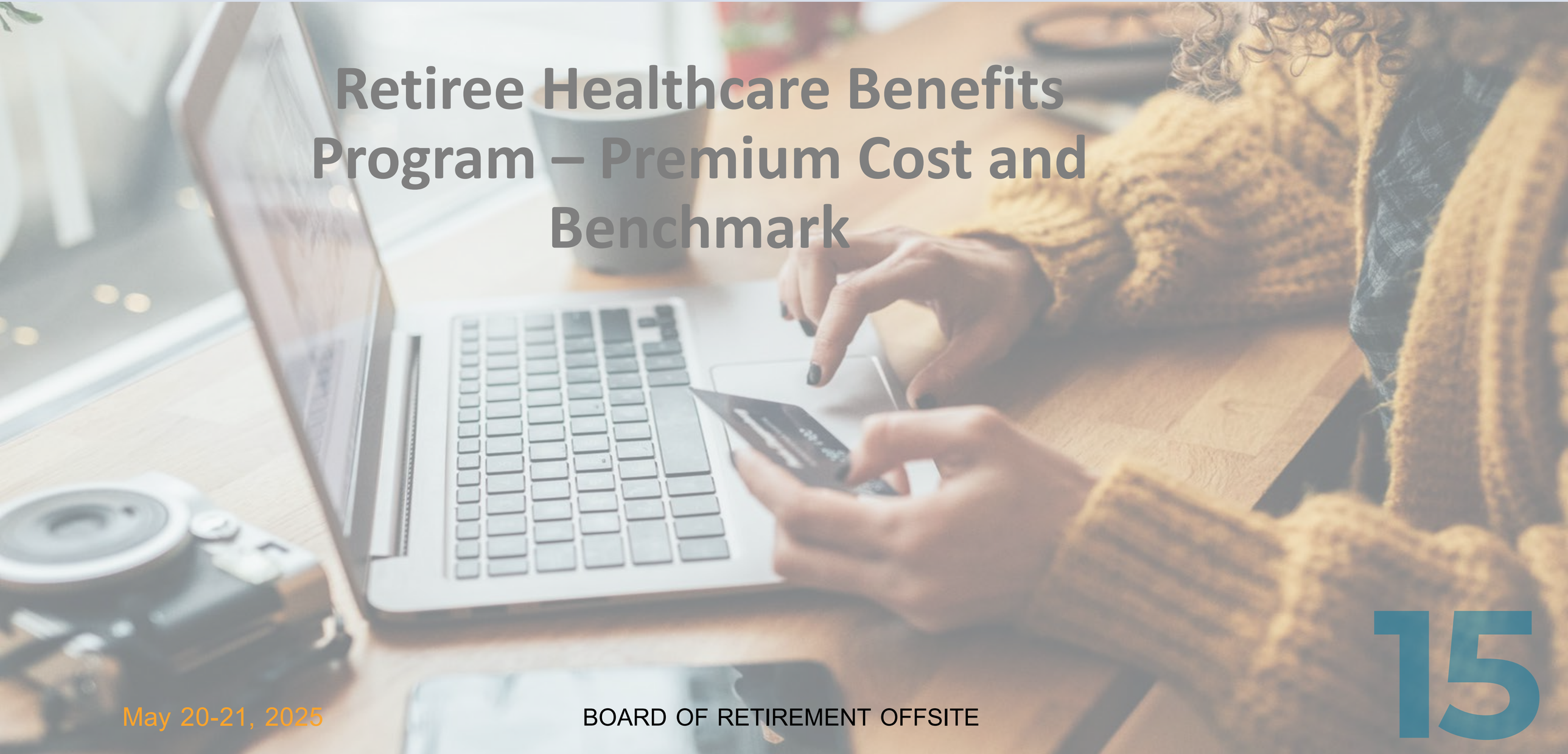
Enrollment Process

- Members must submit enrollments within 60 days of their retirement date or Board letter date (whichever is later) otherwise, the late enrollment rules apply:
  - 6 month wait for medical
  - 12 month wait for dental/vision

- Once documents are imaged into member's account, an acknowledgement letter will automatically be sent out.
- Local 1014 – members must contact Local 1014 directly
- If member wishes to waive, they can submit a waiver to LACERA

LACERA
Los Angeles County Employees Retirement Association

Retiree Healthcare Benefits Program – Premium Cost and Benchmark



May 20-21, 2025

BOARD OF RETIREMENT OFFSITE

15

Years of Service	Member Pays	County Subsidizes
Under 10	100%	0%
10	60%	40%
11	56%	44%
12	52%	48%
13	48%	52%
14	44%	56%
15	40%	60%
16	36%	64%
17	32%	68%
18	28%	72%
19	24%	76%
20	20%	80%
21	16%	84%
22	12%	88%
23	8%	92%
24	4%	96%
25 or more	0	100%
SCD less than 13 years	50%	50%

Premium Cost and Benchmark

- **County contributes if member has at least 10 years of retirement service credit**
  - **40% of benchmark rate (Anthem I & II) for 10 years of service credit**
  - **4% of benchmark rate for each additional year up to a maximum of 100% for 25 years or more of service credit**
  - **Members will be responsible for the premium difference - if plan selected is above benchmark rate even with 25+ years of service**

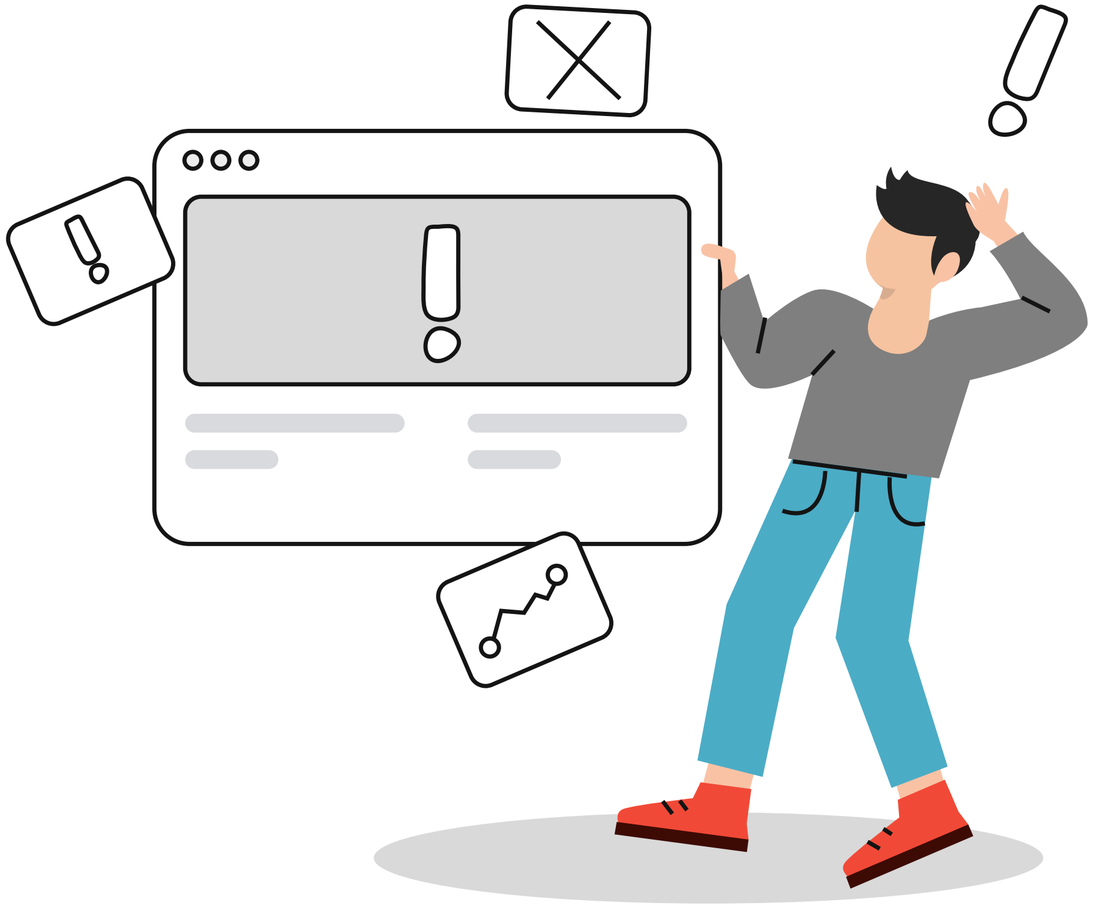
LACERA
Los Angeles County Employees Retirement Association

Benchmark/Premium rates

2025 Benchmark plan rates

2025 Anthem Blue Cross I/II Benchmark plans rates:

- Anthem I/II Retiree only benchmark rate - $1,477.12
- Anthem I/II – Retiree and spouse benchmark rate - $2,857.90
- LACERA administered plans exceeding the benchmark effective July 1, 2025:
  - United Healthcare Commercial plan
  - Cigna Network Model plan



Is a member with 25 years of service guaranteed they will never have a premium?

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Retiree Healthcare Benefits Program – Tier 1 & 2

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Retiree Healthcare Benefits Program – Tier 1

- Hired before June 30, 2014
- Anthem Blue Cross I & II
- Cigna Indemnity Dental/Vision plan

❖**Medicare Enrollment is optional**
❖**Employees hired 01/01/1983 thru 04/30/1986 did not pay Social Security nor Health Insurance Tax (HIT)**

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Retiree Healthcare Benefits Program – Tier 2

- Hired after June 30, 2014

- Anthem Blue Cross I & II – Not eligible for Medicare
- Anthem Blue Cross III – Medicare eligible
- Cigna Indemnity Dental/Vision plan

❖ **Mandatory enrollment in Part A & B when entitled.**
❖ **Part B reimbursement for retiree/survivor only.**
❖ **Premium subsidy applies to retiree/survivor only**


MEDICARE

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Medicare Basics

What is Medicare

Medicare is a Federal health insurance program.

Medicare is a fee-for service plan.

Eligibility requirements

Age 65 or older; or

Under age 65 with certain disabilities; or

Any age with permanent kidney failure.

What does LACERA require

Proof of Medicare Parts A and B or Social Security ineligibility letter.

Annual proof of Medicare Part B premium, as needed.

Fee- for service plan is a health insurance system which doctors, and health care providers are paid a fee for services rendered.

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Medicare Part B Premium Reimbursement Program

May 20-21, 2025

BOARD OF RETIREMENT OFFSITE

25

Medicare Part B Premium Reimbursement Program

The Medicare Part B Premium Reimbursement Program (up to the standard rate only) is:

- **Subject to annual approval by the Board of Supervisors**
- **Tier 1 members - up to 2-party Part B reimbursement**
- **Tier 2 members – only retiree/survivor qualifies for the Part B reimbursement**

- **Annual Part B verification is required (if member pay an amount lower than the standard rate) in order for LACERA to adjust the monthly Part B Premium Reimbursement**

Medicare Part B Premium Reimbursement Program - Requirements

- Members must meet the following requirements:
- Must pay Part B premiums through Social Security deduction or receive a Medicare billing notice.
- Enrolled in a LACERA-administered MAPD or Medicare supplement plan.
- Not being reimbursed by any other agency.

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Strategic Focus

Guide members on their journey as they transition from active to retirement.

Retiree Healthcare Basics video available on our website at www.lacera.com

Intro to Retiree Healthcare and Medicare Enrollment | LACERA

How well do you know our retiree healthcare benefits program now?

1. I could teach a class!
2. I know a thing or two.
3. Wait, what's that again?
4. I'm calling retiree healthcare.


THANK YOU

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Retiree Healthcare Benefits Program: Rights & Obligations Under 1982 Agreement

BOARD OF RETIREMENT OFFSITE

May 20-21, 2025
Day Two

Foundation of Retiree Healthcare Benefits Program (RHCBP)

1982 Agreement (Tier 1)

1994 Amendment Modification No. 1

2014 Amendment Modification No. 2 (Tier 2)

1. 1982 Agreement
   - Background – establishment of RHCBP
   - Legal obligations
   - Summary of benefits under Tier 1
2. 1994 Agreement / Modification No. 1
   - Background
   - Legal obligations
3. 2014 Agreement / Modification No. 2
   - Background
   - Legal obligations
   - Summary of benefits under Tier 2

1

1982 AGREEMENT

Timeline of Retiree Healthcare Benefits Program

1971

- Board of Retirement Creates RHCBP

1982

- County and LACERA signed agreement

1994

- Amendment #1 to 1982 agreement

2014

- Amendment #2 to 1982 agreement (Tier 2)

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1982 Agreement: Background

Retiree Healthcare Benefits Program established in 1971. Plan offerings:

- Occidental (Anthem Blue Cross Plans I and II)
- Blue Cross (Prudent Buyer Plan)
- Kaiser Permanente
- Ross-Loos (Cigna)

1982 Agreement: Background

- Financial bind - LACERA assisted the County to avoid issuing further layoffs within County departments

- Reduced County's retirement benefit contribution rate following an actuarial valuation yielding an estimated annual net County savings of more than $23M

1982 Agreement: County Obligations

- To provide benefits under the RHCBP “not less than” benefits (cost & coverage) being provided by LACERA at that time

- To take over the funding of the RHCBP as of July 1, 1982 and to monthly advance to LACERA the premiums and death benefit payments then being paid by LACERA

- To continue to provide RHCBP benefits *so long as the County provides health benefits for active County employees and their dependents*

1982 Agreement: LACERA Obligations

- To administer the program
- To maintain members' cost share of the premium
- To NOT increase medical/dental/vision benefit levels without the consent of the County
- To implement an actuarial valuation under Cal. Govt. Code §31453

1982 Agreement: Legal Obligations

The parties agreed to:

- Adopt an ordinance authorizing the RHCBP, on the terms agreed upon in the 1982 Agreement (Ordinance No. 5.20.080)

- Seek legislation that will make the County's health insurance requirements of the agreement a statutory requirement and to continue to seek such legislation until it is enacted (amendment to Cal. Govt. Code §31692).

1982 Agreement: Legal Obligations

County Code 5.20.080

- Adopted pursuant to 1982 Agreement
- Specifically authorizes the RHCBP on the terms described in the Agreement

1982 Agreement: Legal Obligations

Amendment of CERL

- AB3229 amended Cal. Govt. Code §31692, which generally provides that retiree health benefits adopted pursuant to §31691 are not vested.

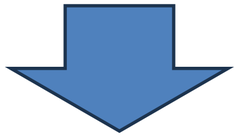
- Amendment: "For counties with a population of 5,000,000 or more, adoption of an ordinance or resolution pursuant to Section 31691 ***shall remain in effect*** for any member heretofore or hereafter retired ***for as long as the board of supervisors or governing body provides similar types of benefits to any active member in current county service***."

1982 Agreement: Legal Obligations

As a result of both

(i) express contractual language of 1982 Agreement and

(ii) statutory amendment of Section 31692



Creation of **vested rights** in the benefits described in the 1982 Agreement for **both retired members and currently active members**

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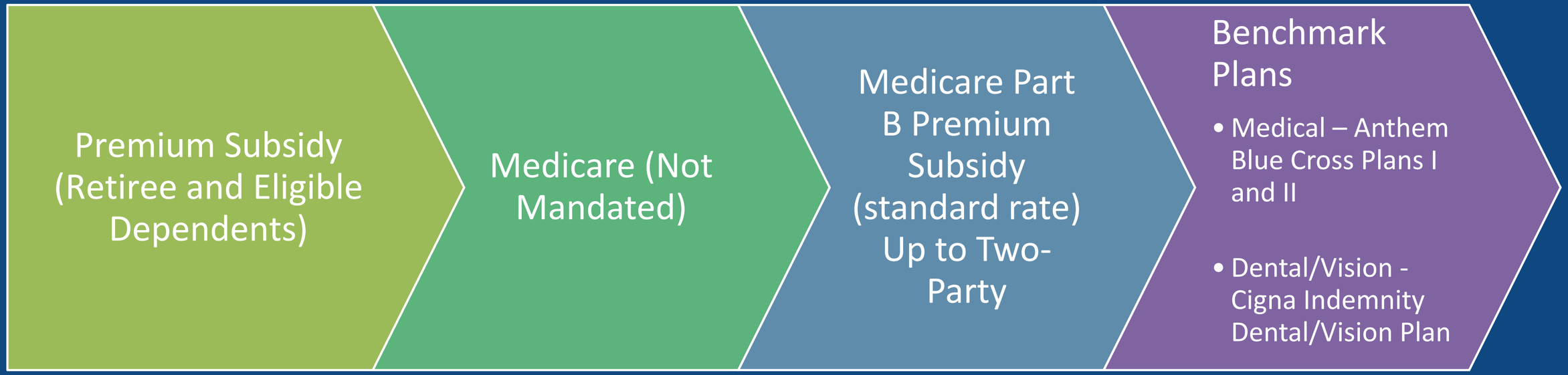
1982 Agreement: Summary of Tier 1 Benefits

LACERA-Administered Retiree Healthcare Benefits Program (County employees hired prior to July 1, 2014)



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1994 AGREEMENT/MODIFICATION NO. 1

1994 Agreement: Background

Agreement was part of a Pension Obligation Bond agreement.

1994 Agreement: County Obligations

- Under 1982 Agreement, County agreed "To continue to provide RHP benefits *so long as the County provides health benefits for active County employees and their dependents*"

- Under 1994 Agreement, County agreed "To continue to provide RHP benefits "***notwithstanding any future termination by the County of the health programs it provides for active employees and their dependent***s"

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2014 AGREEMENT/MODIFICATION NO. 2

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Modification No. 2: Background

Benefits offered would be financially unsustainable in the future.

Modification No. 2: Creation of Tier 2

Key Changes:

- Creation of new “tier” of benefits for “New Members” (hired after June 30, 2014)
- Dependents no longer eligible for County subsidy
- Requirement to enroll in Medicare

Modification No. 2: County Obligations

- Establish certain terms for Tier 2 Plan, set forth in new County Code §5.20.085
    - eligibility of both the “New Members” and their “Eligible Dependents”;
    - method for calculating the County subsidy, including which plans will serve as a benchmark plan
- Paying cost of County subsidy
- Paying LACERA’s costs for administration of Tier 2 Plan

Modification No. 2: LACERA Obligations

- Selecting insurance carriers and negotiating coverage terms and rates
- Establishing rules and procedures for administering, enrolling members in the plan
- Calculating County's share of the subsidy with respect to each member
- Collecting County's subsidy and member's share of the premiums and paying to carriers
- Producing all member communication materials regarding the terms of the Tier 2 plan

Modification No. 2: Legal Obligations

Changes to benefits under the new Tier Two Plan determined to be legally permissible since the change would **only impact future employees** (hired after June 30, 2014). (Memorandum Re Proposed Retiree Health Benefits Program Changes for New County Hires by Olson, Hagel & Fishburn LLP, March 17, 2014)

- ***Future*** employees do not have a vested right in any particular pension (or retiree health benefits) (citing California Association of Professional Scientists (CAPS) v. Schwarzenegger (2006) 137 Cal.App.4th 371)

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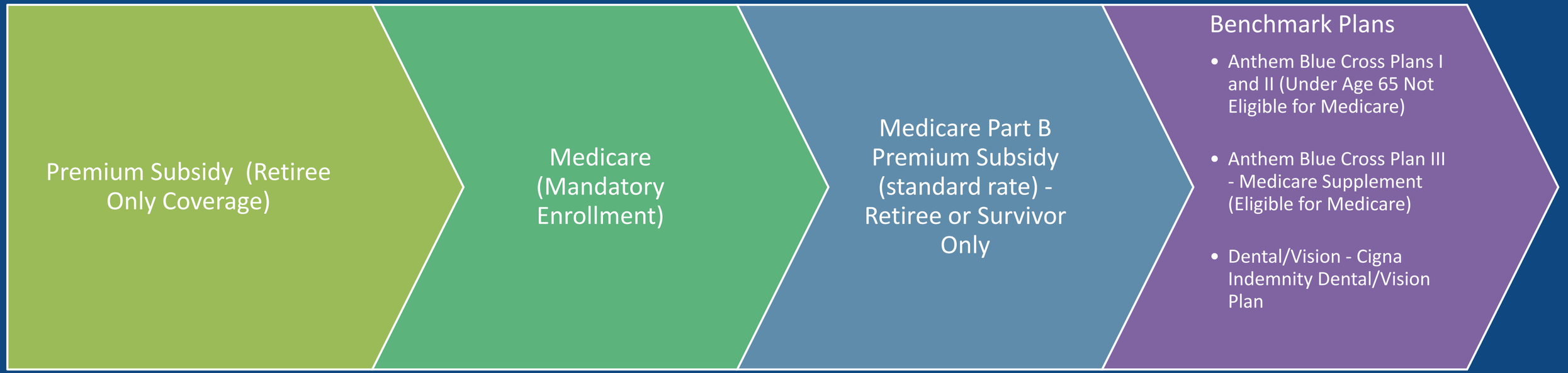
Modification No. 2: Summary of Tier 2 Benefits

Los Angeles County Retiree Healthcare Benefits Program (County Employees Hired after June 30, 2014)



Legal Obligations: No Changes to Benefits without L.A. County Approval

General Rule: Per the 1982 Agreement, LACERA may not make any changes to benefits without the approval of L.A. County (Plan Sponsor)

Exceptions:

1. Carrier Mandated Changes
2. Legally Mandated Changes

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What Changes Have Been Made

- Carrier Mandated Changes

Kaiser prescription drug co-pay from $2.00 to $7.00

2013 – Kaiser Cost Plan termed; members auto-enrolled in Kaiser Senior Advantage Plan

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What Changes Have Been Made

- Federal/State Law Mandated Changes

2000 – AB 88
(Mental Health Parity Coverage)

2014 – SB 1088
(Expanded Coverage for Dependents up to Age 26)

2020 – SB 30
(Domestic Partners Definition Changed)

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What Changes Have Been Made

- County Approved Changes

1992 – Medicare Plan Offering + Medicare Part B Premium Reimbursement Program implemented

2014 – SB 1088: Expanded Coverage for Dependents up to Age 26

2025 – Anthem Blue Cross Prudent Buyer, I and II Plans Lifetime Maximum Benefit Amount Increased

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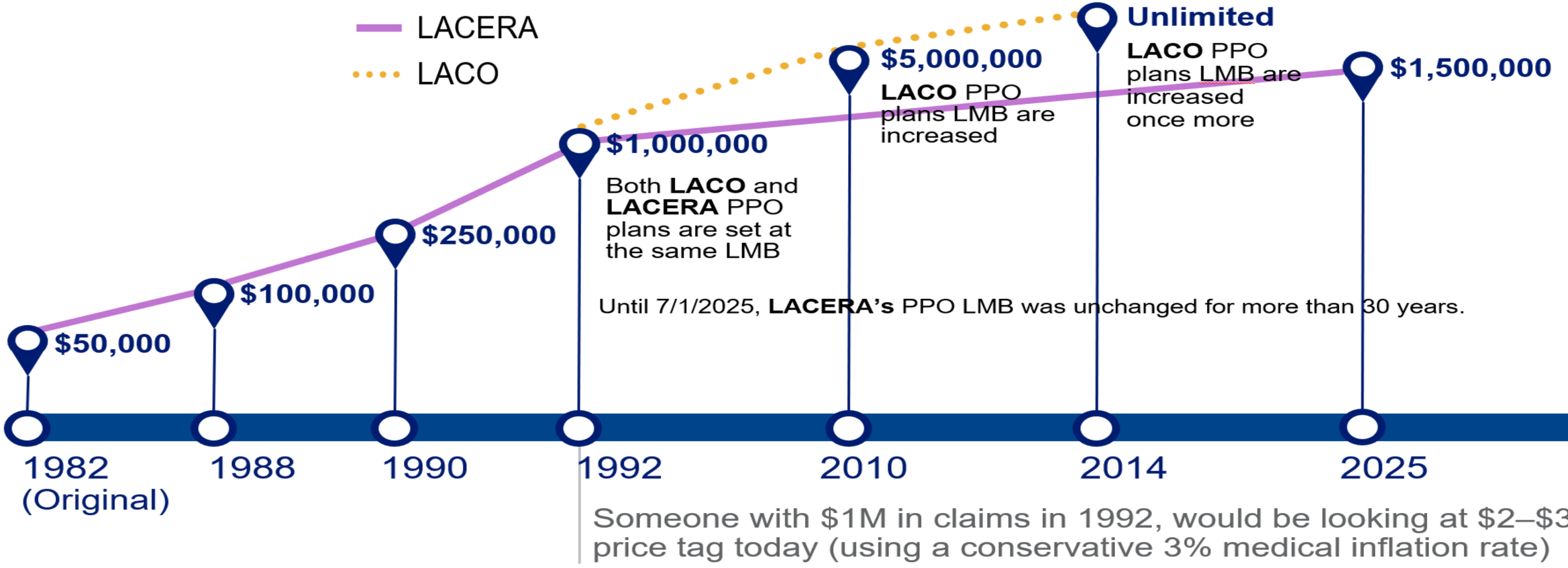
Timeline of Lifetime Maximum Benefit Changes for LACERA and L.A. County PPO Plans



Until 7/1/2025, **LACERA's** PPO LMB was unchanged for more than 30 years.

Someone with $1M in claims in 1992, would be looking at $2–$3M price tag today (using a conservative 3% medical inflation rate)

1

Lifetime Maximum Benefit

- Lifetime maximum benefit applies to Anthem Blue Cross Prudent Buyer, I and II Plans
- Lifetime maximum benefit increase from $1 Million to $1.5 Million effective July 1, 2025

Anthem Blue Cross Plan III (Medicare Supplement Plan) does not have a lifetime maximum benefit

1W

Can LACERA Unilaterally Change or Enhance Retiree Healthcare Benefits?

NO!

Evaluation of Cost and Member Impact

Possible Savings?

Approval Required from the County

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Why isn't LACERA required to go out to bid regularly?

- Provider and treatment disruption
- Members appreciate stability
- Benefit offering must remain as is
- Retiree group only plan = higher risk

Carrier Driven Changes: Termination of Carrier Contract

If carrier decides to drop our membership, what's the process to ensure that we can continue to provide healthcare coverage?

- Carrier to provide advanced notice of intent of termination, per agreement
- Health Plan will offer Group another product that it makes available, as applicable
- LACERA issue an RFP

QUESTIONS?