IN PERSON & VIRTUAL BOARD MEETING

MAY 19, 2026 AT 9:00 AM
BOARD OF RETIREMENT OFFSITE

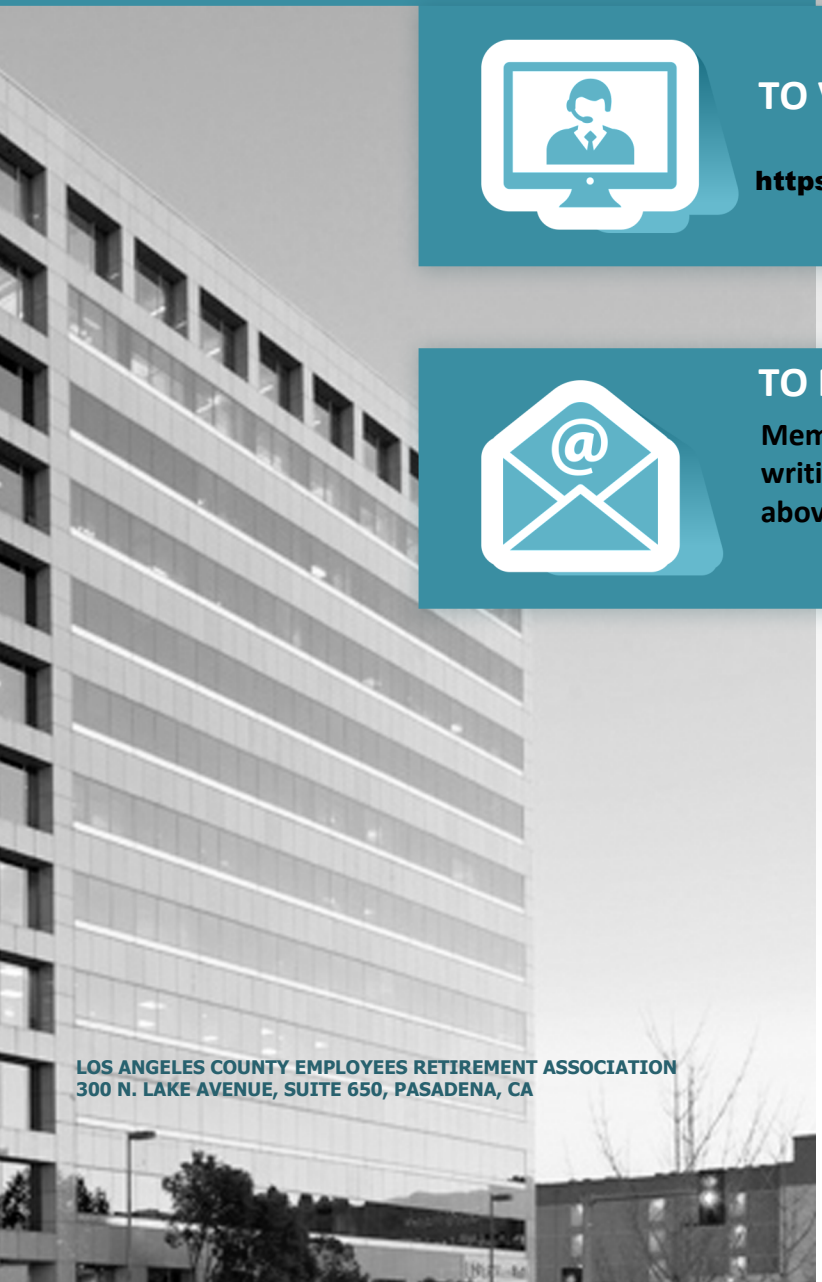
TO VIEW VIA WEB

https://lacera.gov/leadership/board-meetings

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.gov.



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

HYATT REGENCY | 200 S. PINE AVE., LONG BEACH, CA 90802

TUESDAY, MAY 19, 2026 | 9:00 A.M.

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 54953.8.3. Any person may view the meeting online at https://LACERA.gov/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 Senate Bill 707

A. Just Cause (California Government Code Section 54953.8.3)
B. Statement of Persons Present at Teleconference Locations (Senate Bill 707)

Public Comment
(Members of the public may address the Board orally and in writing. To provide Public Comment, you should visit https://lacera.gov/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 Board. 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 & Opening Remarks
Luis A. Lugo, Chief Executive Officer

9:05 a.m. Legal Office's Support for Board and Organizational Processes (Continued)

Overview of Pensionability Determination Process
Jean Kim, Senior Staff Counsel
Ching Fong, Senior Quality Auditor, Quality Assurance

Legal and Quality Assurance will team to provide an overview of the legal authority for LACERA's determinations on whether each LA County or Superior Court pay code is pensionable and the collaboration between the plan sponsors and LACERA in this process. Legal and QA will also share ideas for improvements that have already been implemented and are currently under way.

9:30 a.m. Washington Health Update
Amy Dunn, Senior Vice President and Senior Consultant, Segal, Health Compliance Practice

An update regarding federal legislation affecting retiree healthcare programs.

10:15 a.m. ***Break***

10:30 a.m. Healthcare Landscape: Medical and Prescription Drug Plan Trend Highlights

Daljit Johl, Vice President and Pharmacy Benefits Consultant, Segal
Stephen Murphy, Sr. Vice President and Benefits Consultant, Segal
Michael Szeto, Senior Actuarial Associate, Segal

Segal consultants Daljit Johl, Stephen Murphy, and Michael Szeto will present highlights from the 2026 Segal Health Plan Cost Trend Survey, with a focus on retiree healthcare plans and market trends representing over 80 percent of the commercial and self-insured population.

11:15 a.m. Retiree Healthcare Division – Overview of Fiscal Operations

Cassandra Smith, Director, Retiree Healthcare
Ted Granger, Chief Financial Officer

LACERA staff will present an overview of the Retiree Healthcare (RHC) Program fiscal operations, covering how insurance premium renewals are negotiated and approved on an annual cycle, the financial accounts that support the program (totaling roughly $6.1 billion across the OPEB Trust, premium reserves, and other funds), and the governance framework of actuarial valuations, audits, and board reporting.

12:15 p.m. ***Lunch***

1:15 p.m. SWOT Analysis: Transitioning Retiree Healthcare from a Fiscal to Calendar Plan Year

Cassandra Smith, Director, Retiree Healthcare
Stephen Murphy, Sr. Vice President and Benefits Consultant, Segal

LACERA staff members Cassandra Smith, joined by Stephen Murphy from Segal, will discuss key operational, financial, and member-impact considerations associated with transitioning Retiree Healthcare programs from a fiscal to a calendar plan year.

2:15 p.m. ***Break***

2:30 p.m. GLP-1 Panel Discussion

Stephen Murphy, Sr. Vice President and Benefits Consultant, Segal
Joseph Karam, MD, Anthem
Soo Rhee, MD, CVS
Kimberly Petrick, MD, Kaiser Permanente

Representatives from Anthem, CVS, and Kaiser Permanente will provide an overview of GLP-1 therapies, their expanding clinical indications, and how California's Departments of Managed Health Care and Insurance affect member access and eligibility.

3:30 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 that are distributed to members of the Board of Retirement 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 of Retirement 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.gov, but no later than 48 hours prior to the time the meeting is to commence.

LEGAL OFFICE

Pensionability Determination Process

JEAN KIM
Senior Staff Counsel

CHING FONG
Senior Quality Auditor, Quality Assurance

What is Pensionability?

*Determining which items of compensation qualify as **pensionable** for inclusion in the member's final compensation is a core function of LACERA.*

Process for Determining Pensionability

Process for Determining Pensionability

1. Request Sent to LACERA

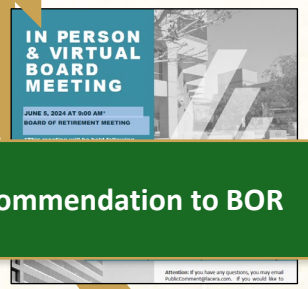
Chief Executive Office.

2-way communication

2. QA Fact Gathering

3. QA Drafts Analysis

4. Legal Prepares BOR Memo



5. Recommendation to BOR

6. Report BOR's Pensionability Determinations to County or Court

QA Review

Pay item information gathering — the 4 W's plus How.

SOURCE DOCUMENTS

- Memoranda of Understanding (MOUs)
- Terms of Successor MOUs
- Side Letter Agreements
- Board of Supervisors Memos
- Department Correspondence

PAY ITEM ANALYSIS

WHO	*is eligible — classifications, groups, paid to all, available to all?*
WHAT	*is the purpose, pay rate, and description?*
WHEN	*is the payment made — start, end, frequency?*
WHY/HOW	*do employees qualify — eligibility criteria, automatic?*
HOW	*is it paid — base salary % increase, flat dollar bonus, one-time, ad hoc?*

COMPARE · *Legal definitions in CERL and PEPRA*

FORWARD · *Pay item analysis to Legal Office*

Legal Review of Pensionability: 3 Step Process

01

Compensation

Gov. Code § 31460

02

Compensation Earnable or Pensionable Compensation

Gov. Code § 31461; Gov. Code § 7522.34

03

Exclusions

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Gov. Code § 31461; Gov. Code § 7522.34

Legal Review: Step 1 - Compensation

Is the pay item “compensation”?

Compensation: “remuneration paid in cash out of county or district funds” Govt. Code § 31460

Example: Living allowance stipend for JusticeCorps volunteers working at Court – not employees, not compensation

Legal Review: Step 2 – Compensation Earnable or Pensionable Compensation

FRAMEWORK 01

LEGACY MEMBERS

Compensation Earnable

Govt. Code § 31461

Average compensation determined by the Board, for the period under consideration, on the basis of average days ordinarily worked by similarly situated members, at the same rate of pay.

FRAMEWORK 02

PEPRA MEMBERS

Pensionable Compensation

Govt. Code § 7522.34

Normal monthly rate of pay or base pay paid in cash to similarly situated members of the same group or class for services rendered on a full-time basis during normal working hours, pursuant to a publicly available pay schedule.

Legal Review: Step 3 – Statutory Exclusions

Compensation Earnable – 4 Exclusions

- Catch all: any compensation determined by the board to have been paid to enhance a member's retirement benefit – compensation for in kind payments, any one time or ad hoc payment **that is not made to all similarly situated members in the same grade or class**
- Payments for unused vacation or leave, **in an amount that exceeds that which may be earned and payable in a 12 month period**
- Overtime pay
- Payments made in connection with the termination of employment

Pensionable Compensation – 12 Exclusions

- Any one-time or ad hoc payments
- Any employer provided allowance, reimbursement or payment
- Payments for unused vacation or leave, regardless of when reported or paid
- Any bonus paid in addition to compensation **(unless paid to everyone in the class or group and is embedded in base pay)**

Examples

How the same pay item is treated under each framework.

PAY ITEM	COMPENSATION EARNABLE (LEGACY) · § 31461	PENSIONABLE COMPENSATION (PEPRA)·§ 7522.34
Overtime Pay	✕ Not Pensionable Statutorily excluded	✕ Not Pensionable Statutorily excluded
MOU Lump Sum Bonus One-time payment made to all bargaining unit members following ratification of MOU	✓ **Pensionable** One-time payment that is paid to everyone in class	✕ Not Pensionable One-time payment
Catalina Island Living Bonus (Firefighters) Paid to firefighters required to reside in Catalina who are assigned to beach and boat rescue operations	✓ **Pensionable** Percentage bonus embedded in base salary rate	✓ **Pensionable** Percentage bonus embedded in base salary rate and paid to all in group

Improvements

LEGAL OFFICE

2026 Pensionability Calendar

County/Court → QA	QA → Legal	Legal → Support	Tentative Agenda	Exec Review	Final PDF	BOR Meeting
Fri Dec 19	Mon Jan 6	Tue Jan 20	Tue Jan 20	Wed Jan 21	Tue Jan 27	**Wed Feb 4**
Fri Jan 16	Mon Feb 3	Tue Feb 17	Tue Feb 17	Wed Feb 18	Tue Feb 24	**Wed Mar 4**
Fri Feb 13	Mon Mar 2	Mon Mar 16	Mon Mar 16	Wed Mar 18	Tue Mar 24	**Wed Apr 1**
Fri Mar 13	Mon Apr 6	Mon Apr 20	Mon Apr 20	Wed Apr 22	Tue Apr 28	**Wed May 6**
Fri Apr 17	Mon May 4	Mon May 18	Mon May 18	Wed May 20	Tue May 26	**Wed Jun 3**
Tue May 15	Mon Jun 1	Mon Jun 15	Mon Jun 15	Wed Jun 17	Tue Jun 23	**Wed Jul 1**
Fri Jun 12	Mon Jul 7	Mon Jul 20	Mon Jul 20	Wed Jul 22	Tue Jul 28	**Wed Aug 5**
Fri Jul 17	Mon Aug 3	Mon Aug 17	Mon Aug 17	Wed Aug 19	Tue Aug 25	**Wed Sep 2**
Fri Aug 14	Mon Sep 7	Mon Sep 21	Mon Sep 21	Wed Sep 23	Tue Sep 29	**Wed Oct 7**
Fri Sep 18	Mon Oct 5	Mon Oct 19	Mon Oct 19	Wed Oct 21	Tue Oct 27	**Wed Nov 4**
Tue Oct 16	Mon Nov 2	Mon Nov 16	Mon Nov 16	Tue Nov 17	Mon Nov 23	**Wed Dec 2**

Ongoing Process Improvements

- Formalizing the review process by QA
- Creating a library of past legal determinations

Thank You

Segal

LACERA

Washington Health Update

May 19, 2026 / Amy Dunn

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:
- Part D standard deductible $615 for 2026 ($700 for 2027)
- Part D out-of-pocket maximum $2,100 for 2026 ($2,400 for 2027)
- Guidelines for 2027 Part D plans were released January 2026, and were finalized in April 2026

Medicare Rx Negotiation

On January 27, 2026, CMS announced selection of the below list of 15 drugs payable under Medicare Part B and/or covered under Medicare Part D for the third cycle of negotiations (initial price applicability year 2028), based on total expenditures for drugs payable under Part B and/or covered under Part D and other criteria as required by the law.

- The next set of 15 drugs include:
  - Trulicity (Type 2 Diabetes)
  - Biktarvy (HIV-1 Infection)
  - Orencia (Rheumatoid and Psoriatic Arthritis)
  - Botox (Chronic Migraines)

Source: Fact Sheet: Medicare Drug Price Negotiation Program

Status of GLP-1 BALANCE and Bridge Models

- CMS has announced the BALANCE (Better Approaches to Lifestyle And Nutrition for Comprehensive hEalth) model, that would allow Medicare coverage of GLP-1 drugs for obesity, will not start on January 1, 2027
- The delay is due to limited participation from Medicare Part D sponsors
- CMS signaled it will continue its negotiations with Part D sponsors
- The Bridge Program was created as a temporary pathway to provide earlier access to GLP-1 drugs while CMS negotiates with carriers
- Originally scheduled to end December 31, 2026, the Bridge program will continue to run from July 1, 2026, through December 31, 2027

Part D GLP-1 Bridge Program

- The program will provide early access to specific GLP-1 medications (such as Wegovy and Zepbound) for weight loss and long-term weight maintenance
- Coverage applies to specific drugs chosen by CMS, not all GLP-1 drugs will qualify
- Eligible beneficiaries are Part D enrollees with a certain BMI or with specific chronic conditions/diagnoses
- Eligible beneficiaries will pay a fixed $50 copay, with no deductible applied
- Payments do not count toward Part D Out-of-Pocket Maximum
- Program runs directly from CMS to participating pharmacies, not through the Part D plan itself

Legislative Update

CAA 2026 - PBM Reporting and Fee Disclosures

- The Consolidated Appropriations Act (CAA) of 2026, signed into law on February 3, 2026, enacts full-year funding of five appropriations bills, and makes significant reforms to pharmacy benefit manager (PBM) practices
- The PBM reforms affect employment-based group health plans and insurers, as well as Medicare
- Generally, the CAA's PBM provisions are effective for plan years beginning on or after August 3, 2028 (i.e., 30 months after the law's enactment date)
- For calendar-year plans, the PBM requirements would be effective for plan years beginning on January 1, 2029

CAA 2026 - Mandatory PBM reporting

- PBMs would be required to submit reports at least every six (6) months to large plans and employers with over 100 participants
- Reports must list drug claim information and provide detailed information about:
  - Compensation
  - Gross and net drug spending,
  - Drug rebates,
  - Spread pricing arrangements,
  - Formulary placement rationale, and information about benefit designs that encourage the use of pharmacies affiliated with PBMs

CAA 2026 - Mandatory plan reporting

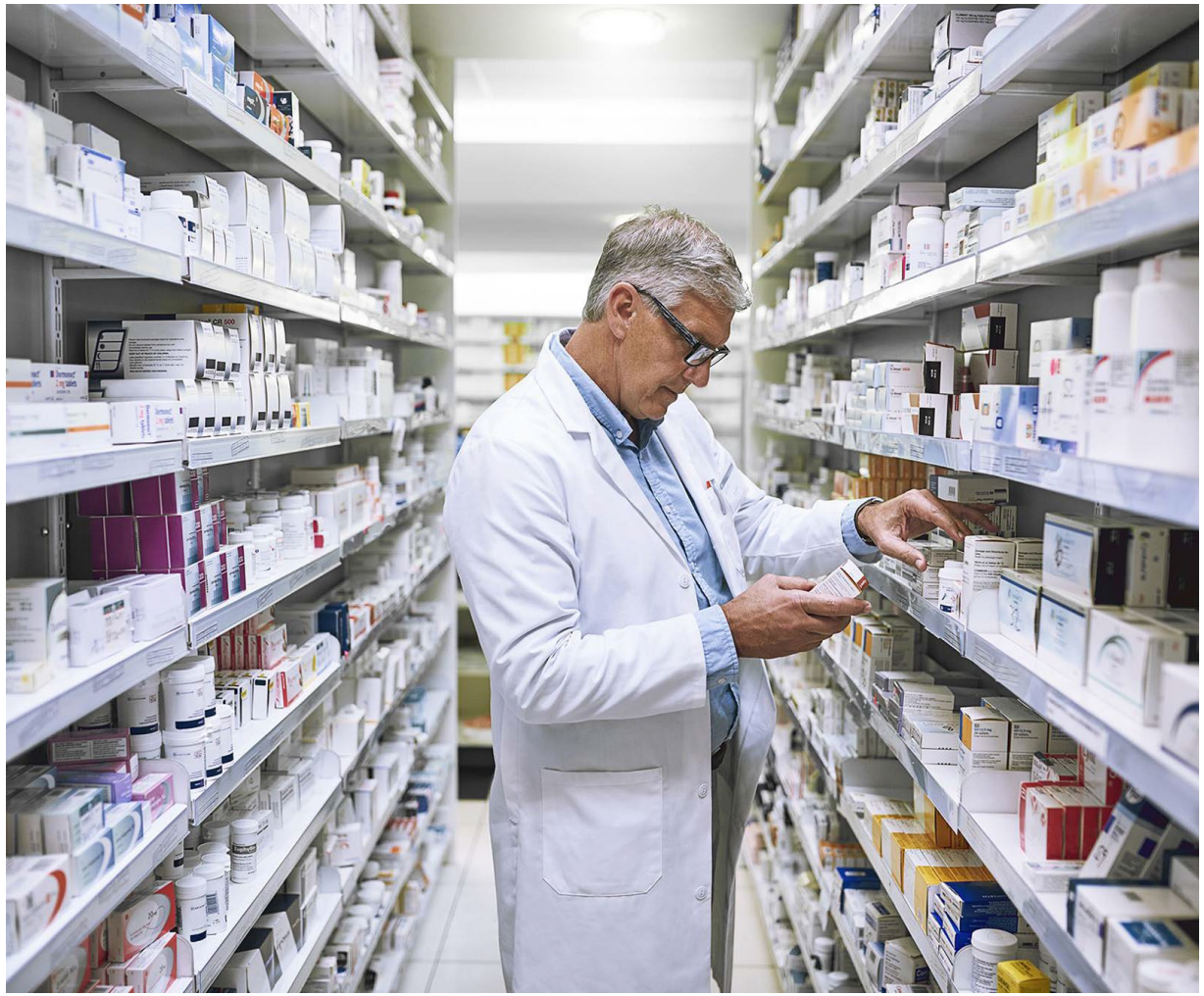
- Each plan year, group health plans must provide written notice to each participant or beneficiary informing them of the requirement for entities providing PBM services to submit reporting to the plan. Notices may be incorporated into plan documents or via individual notification
- Additionally, group health plans must provide the following information to participants and beneficiaries upon request:
  - The participant-facing PBM summary document described above
  - For each claim made by or on behalf of the participant or beneficiary, the difference between the compensation paid by the plan and the compensation paid to the pharmacy

CAA 2026 - Medicare Part D

- Definition of a PBM
- Delinked, transparent compensation and pass-through of rebates
- Additional PBM agreement requirements
- Standardized reporting requirements
- Audits

Regulatory Update

Most-Favored-Nation Prescription Drug Policy



On December 22, 2025, the Administration proposed two Medicare pilot programs to reduce prices for both brand name drugs and drugs administered in a provider's office

Both programs would have mandatory requirements to provide rebates equal to the difference between prices in the U.S. and an international benchmark, based on what 19 other comparable countries pay

The President emphasized proposed MFN policy in a recent speech at the World Economic Forum in Davos and stated that achieving lower prices through MFN policy would not have been possible without using tariffs as leverage

Most-Favored-Nation Prescription Drug Policy

-*Continued*

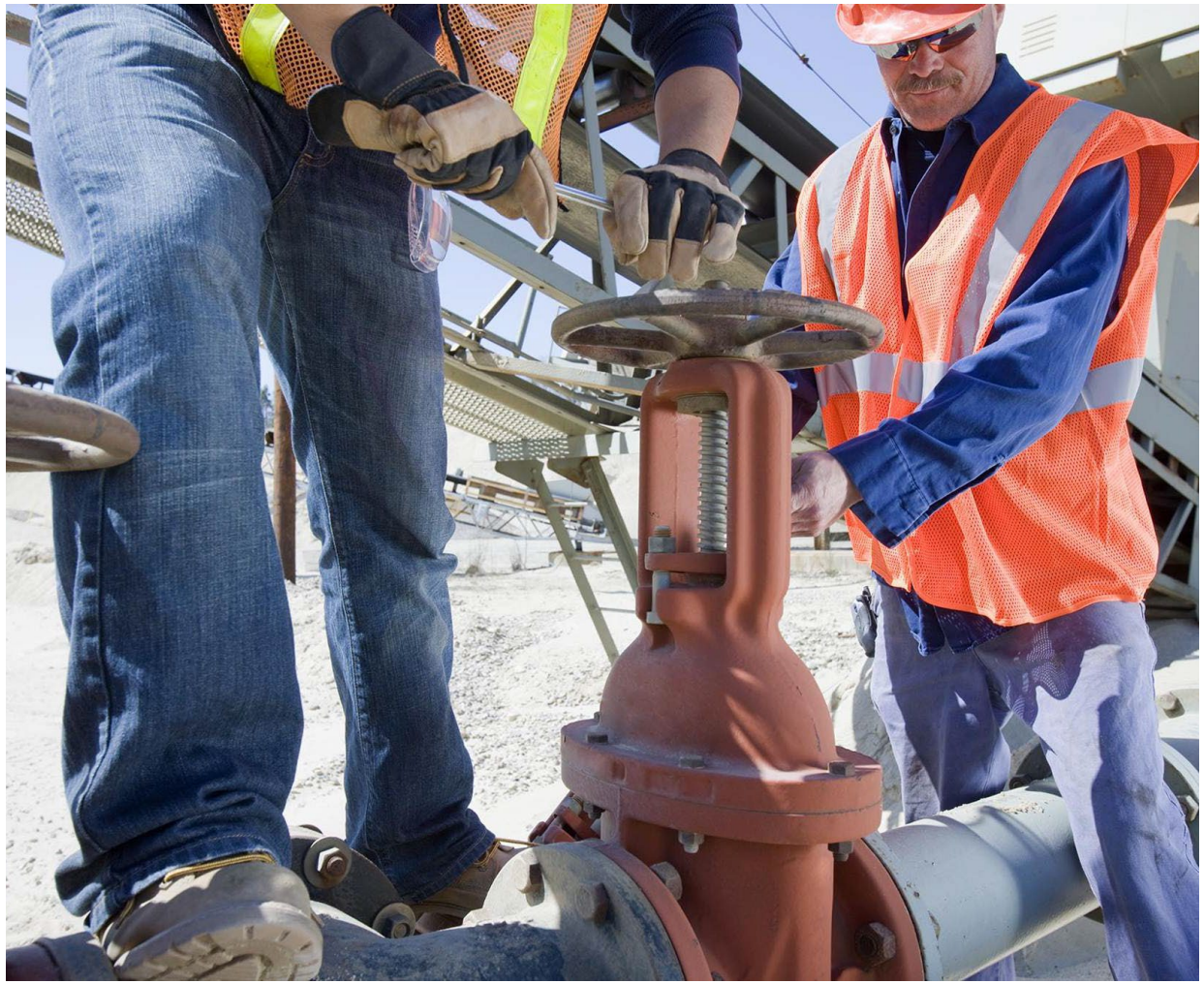
- The Global Benchmark for Efficient Drug Pricing (GLOBE) Model would apply to Part B drugs administered by a physician, and would begin on October 1, 2026, if approved
- The Guarding US Medicare Against Rising Drug Costs (GUARD) Model would apply to Part D retail drugs and would begin on January 1, 2027, if approved
- Both programs are pending a Final Rule, anticipated by August 2026

The Great Healthcare Plan

- Announced by the White House on January 15, 2026
- The Plan announces policies for lowering drug prices, lowering insurance premiums, holding big insurance companies accountable, and maximizing price transparency
- The plan does not specifically address extension of the enhanced premium assistance tax credits for ACA plans, which expired at the end of December 2025
- Some of the proposals included in the plan are already included in proposals the administration has released, including its most-favored-nation pricing proposals for Medicare Part B and D and new proposed rules for transparency in coverage. Other proposals in the plan would require legislative action, including PBM reform measures currently pending in Congress

Regulatory Outlook

- Regulations in the pipeline
  - Regulations updating the No Surprises Act Independent Dispute Resolution process
- Trump Rx: Will offer direct-to-consumer pricing on GLP1 and fertility drugs, among others



TrumpRX Website Live February 2026

- Over 40* medications available through coupons or links to manufacturer direct-to-consumer pay sites, including GLP-1s and fertility medications
- Medication brands listed may have generic or generic alternatives available that may provide greater cost savings
- Patients should not use the TrumpRx site without doing additional research
- Patients should evaluate costs compared to other options

* 43 medications as of today

Thank You and Questions

Biography

Amy Dunn

Senior Vice President, Senior Consultant,
Compliance – Health, Los Angeles

Expertise

Amy is a Senior Vice President and Senior Consultant in the Compliance — Health practice based in Segal's Los Angeles 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. In addition, Amy has developed technical expertise in health transparency rules, mental health parity requirements, summaries of benefits and coverage documentation.

Educational background

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).

LACERA

Healthcare Landscape: Medical and Prescription Drug Plan Trend Highlights

A Discussion of Today's Healthcare Cost Trends

May 19, 2026 / Daljit Johl, Stephen Murphy, Michael Szeto

Segal

Agenda

Results of 2026 *Segal Health Plan Cost Trend Survey*

What's Behind the Numbers

What Drives Trend?

Top Medical Cost Management Strategies

Top Rx Cost Management Strategies

Questions?

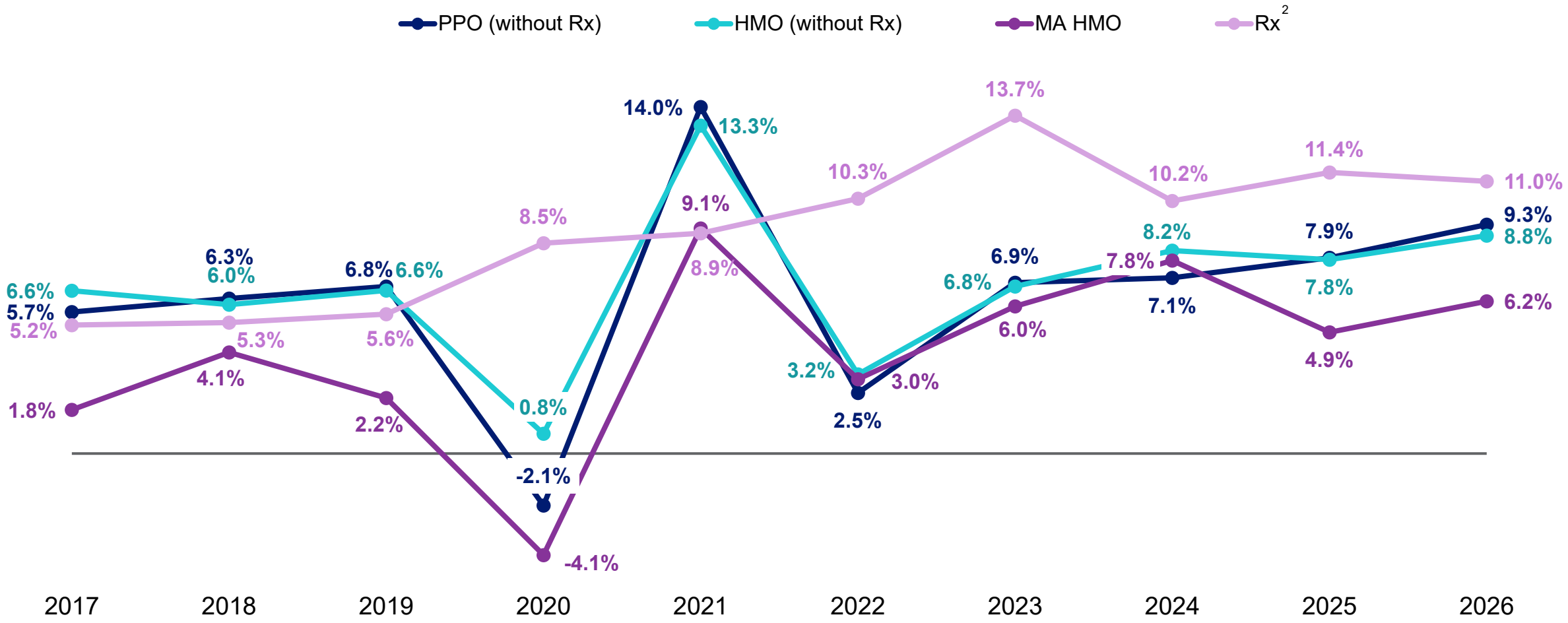
Segal Health Plan Cost Trend Survey Overview

2026 edition is our 29th annual national survey

Survey respondents represent more than 80 percent of the commercially insured and self-insured market and include:

- **Aetna (Acquired by CVS Health in 2018)**
- **Blue Shield of California**
- **Cigna**
- **Elevance Health (Anthem Blue Cross)**
- **Health Net**
- **Kaiser Permanente**
- **United Healthcare**

Ten-Year Summary of Selected Medical and Rx Trends:
2017–2024 Actual and 2025 and 2026 Projected[1]



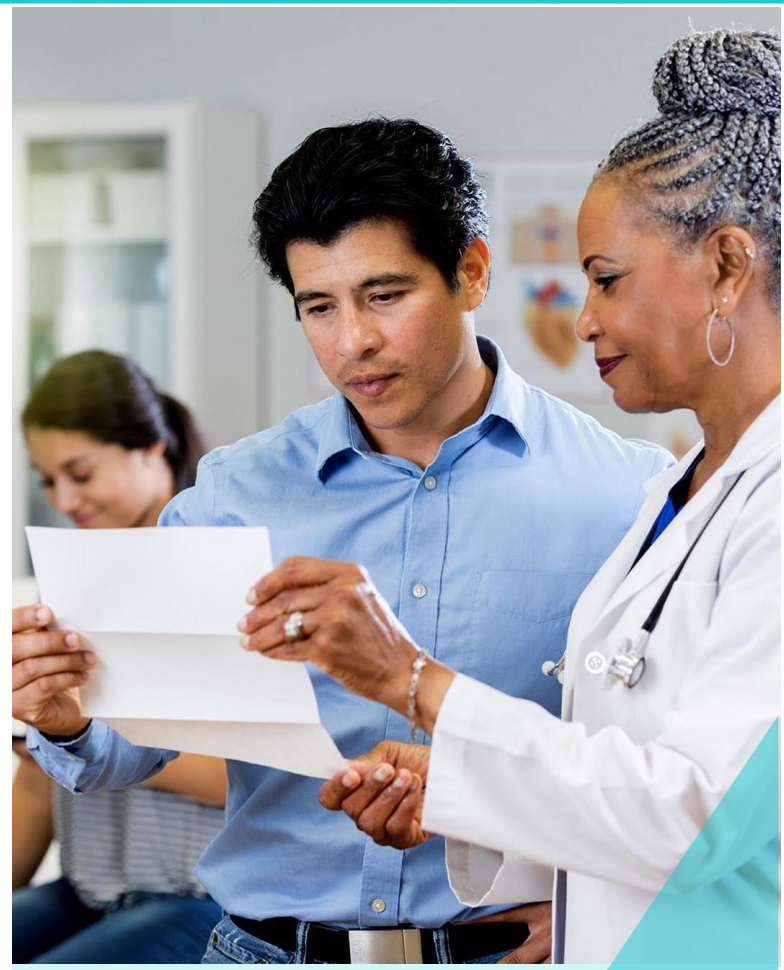
Source: 2026 *Segal Health Plan Cost Trend Survey*

[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.

Behind the Numbers: Medical

1. Projected PPO plan trends are 9.3% for 2026, the highest projection in more than a decade.
2. While unit cost, including factors like price inflation, is still the primary driver for hospital trends, utilization and intensity of services are becoming key drivers in physician trends
3. Hospital unit cost is the largest component of 2026 medical trends.
   - Overall medical price inflation is being driven up by rising labor costs, regulatory changes and ongoing workforce shortages
4. Outpatient Hospital trends were highest of all settings in 2024 at 10.1%, driven by higher acuity utilization.
5. Professional expense trend has increased significantly over the last three years, from 1.9 percent in 2022 to 8.3 percent in 2024
   - Utilization increases are the primary driver, due to demand for services

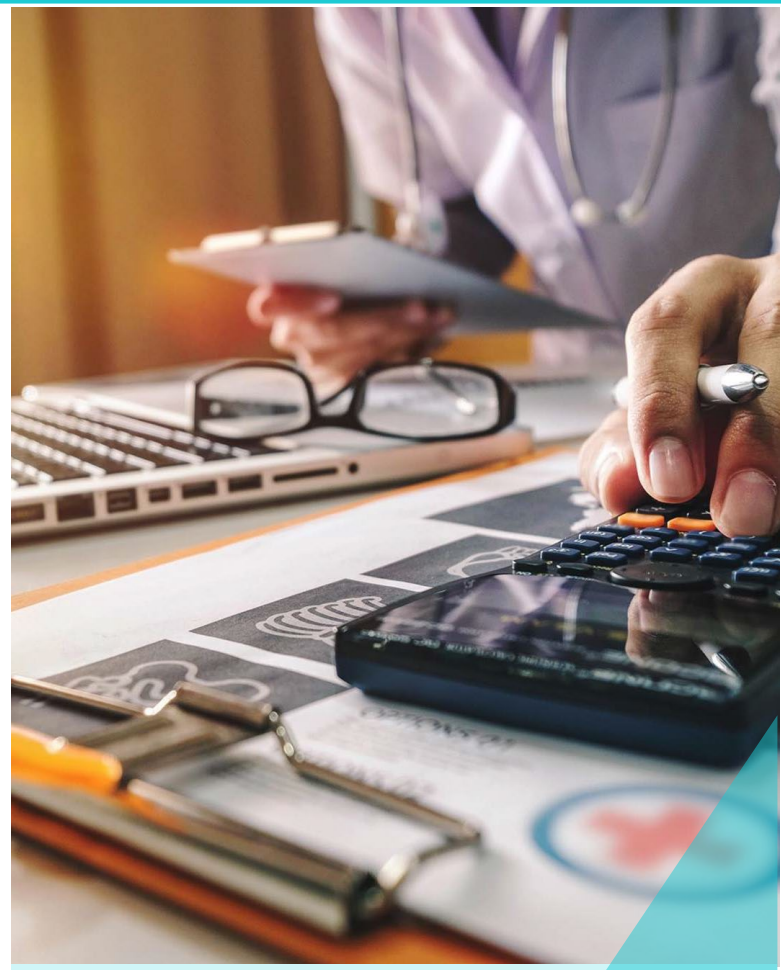


Behind the Numbers: Rx

1. For 2026, the projected annual cost trend for Rx is 11.0%, similar to levels seen in the prior year. Many of the same top drivers continue to be observed, including:
   - new therapies
   - manufacturer price increases, and
   - steady utilization gains in top categories, particularly diabetes
2. For 2024, actual prescription drug cost trends continue to be in the double digits, at 10.2% as reported by carriers and PBMs.
3. SHAPE data shows 13.7% Rx trend as of December 2024. Rx plan cost trend are almost 6% higher in 2024 for plans that cover GLP-1s for weight loss than those that don't.
   - 14.8% trend when coverage includes anti-obesity medications (AOMs) vs. 9.2% when coverage excludes AOMs
4. Specialty drug cost trend remains in the double-digits, driven by:
   - Utilization changes, accounting for 62 percent of the gross cost trend increase before rebates
   - High list price increases

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
- Regulatory changes (e.g., One Big Beautiful Bill Act)
- Social and economic factors, which can influence utilization or care decisions
- Erosion effect of fixed deductibles and copayments



Plan Sponsors' Experience May Differ from Projections

Prevalence of **high cost, catastrophic** claim events

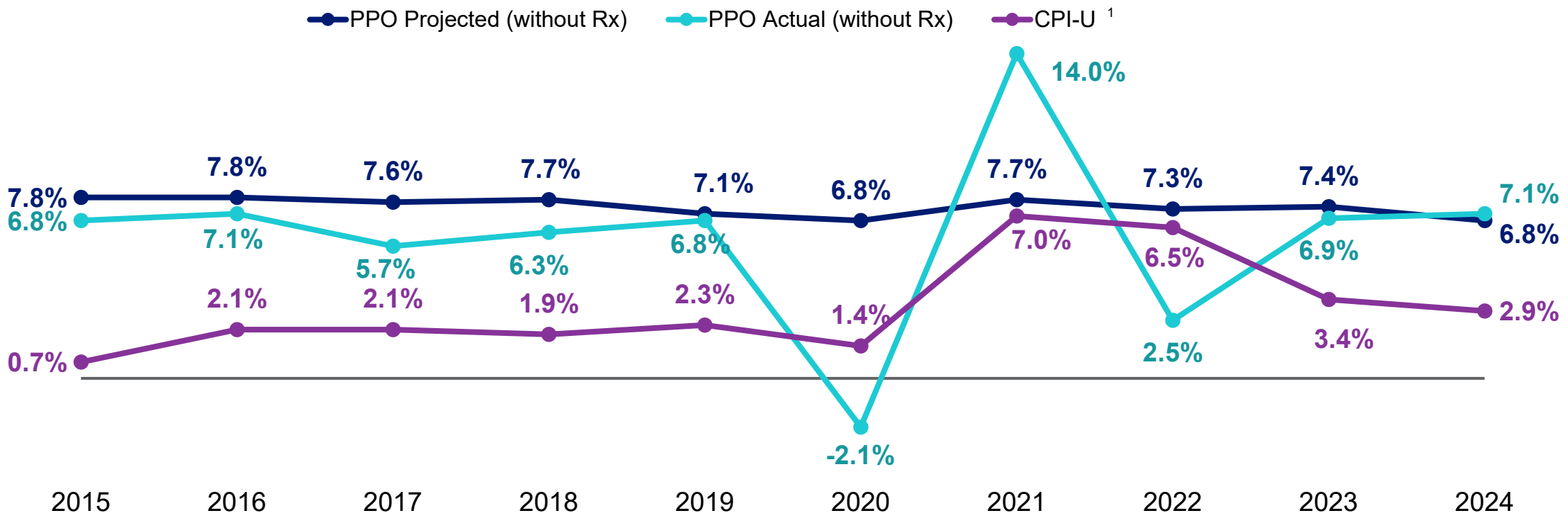
Investment and use of **effective cost management programs**

Choice of Provider Networks — Non-competitive pricing terms

Appropriate plan design features that support effective use of lower cost treatments and providers

Comparison of Projected to Actual PPO Trends

Comparison of Projected to Actual Trends for PPOs
For Actives and Non-Medicare Retirees: 2015–2024

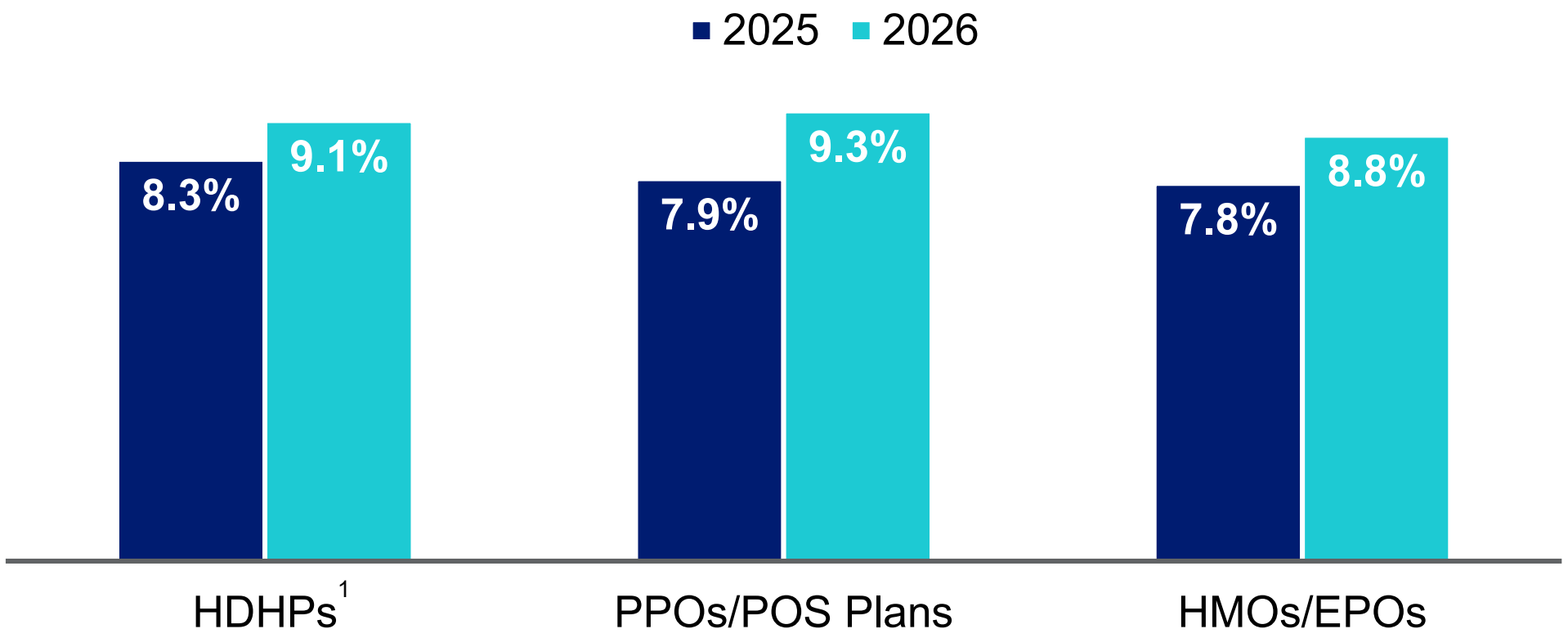


Results based on annual survey of Health Insurers, HMOs and TPAs.

Source: 2026 *Segal Health Plan Cost Trend Survey*

[1] Bureau of Labor Statistics. (n.d.). Consumer Price Index - Historical Data. Retrieved Historical CPI-U, July 2025 (database) (PDF), located on this page: https://www.bls.gov/cpi/tables/supplemental-files/. CPI-U shown is as of December for each year.

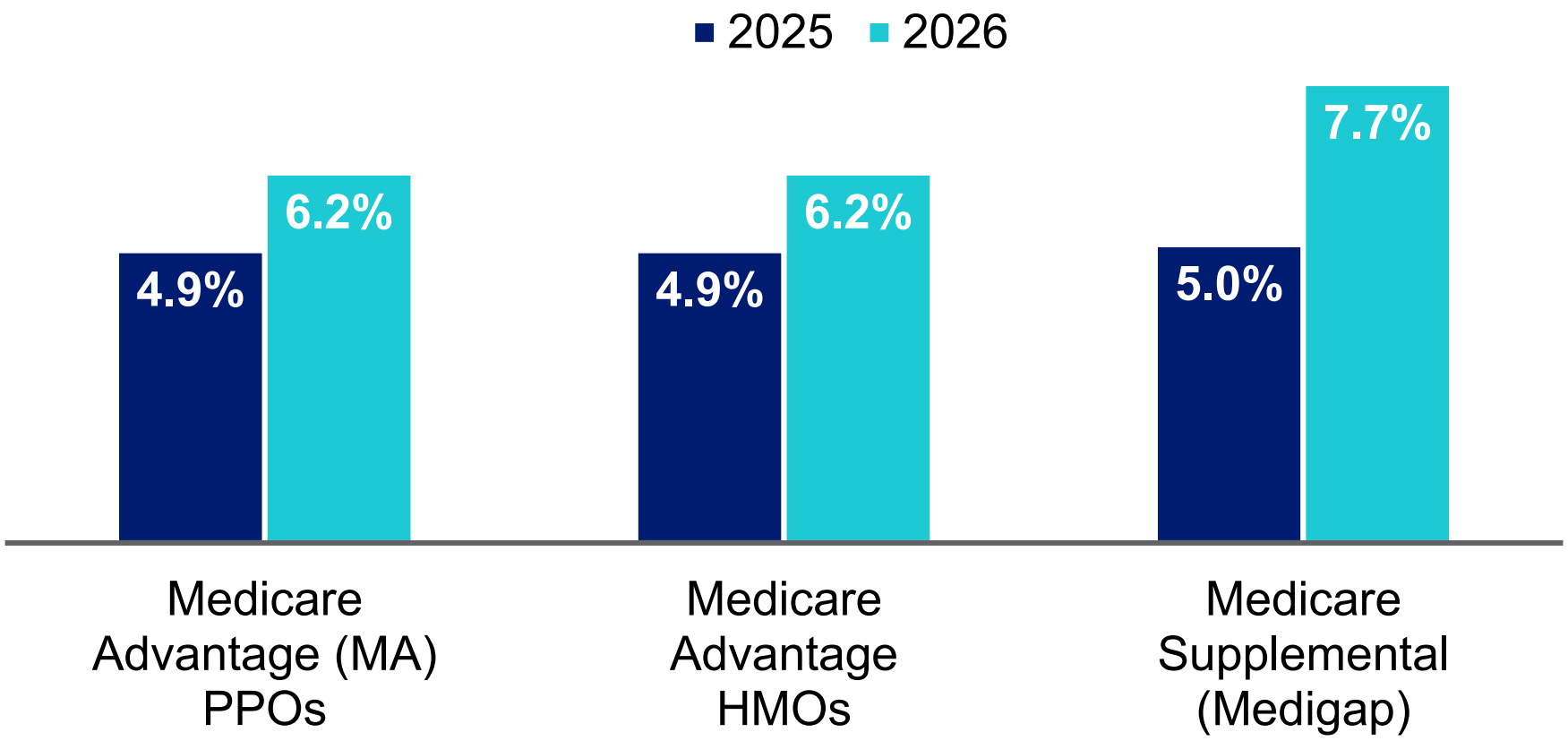
Projected Medical Trends for Actives and Non-Medicare Retirees: 2025 and 2026



Source: 2026 *Segal Health Plan Cost Trend Survey*

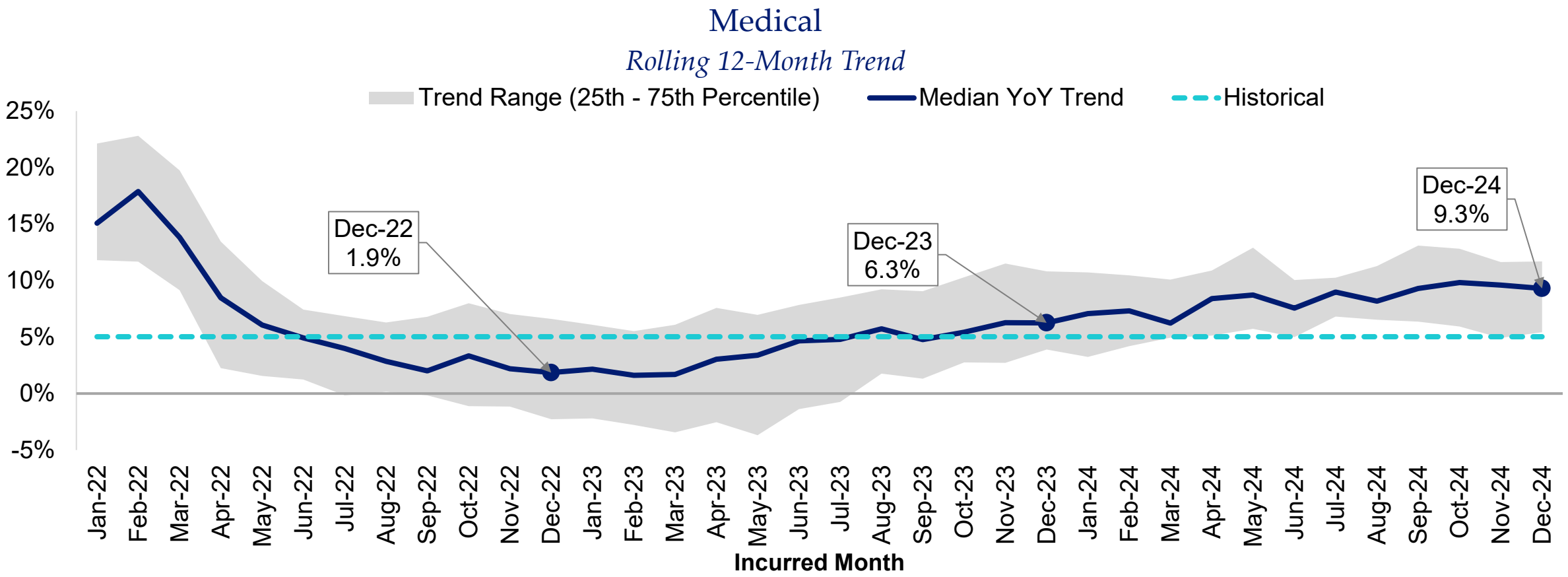
[1] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of healthcare services.

Projected Medical Trends for Medicare Retirees: 2025 and 2026



Source: 2026 *Segal Health Plan Cost Trend Survey*

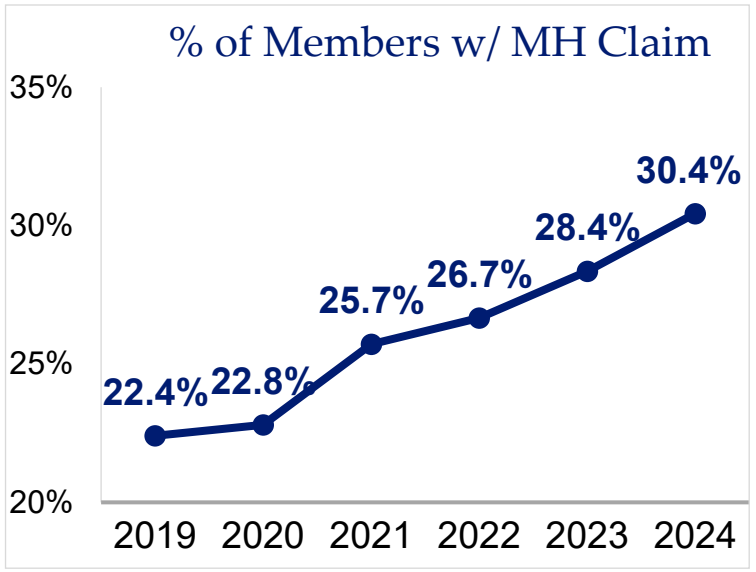
Medical Trend Summary
% Change in Allowed PMPM

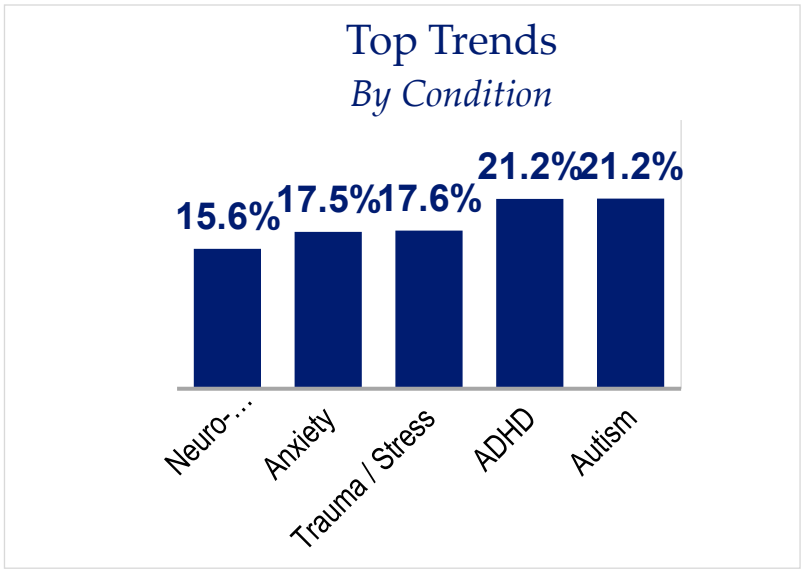


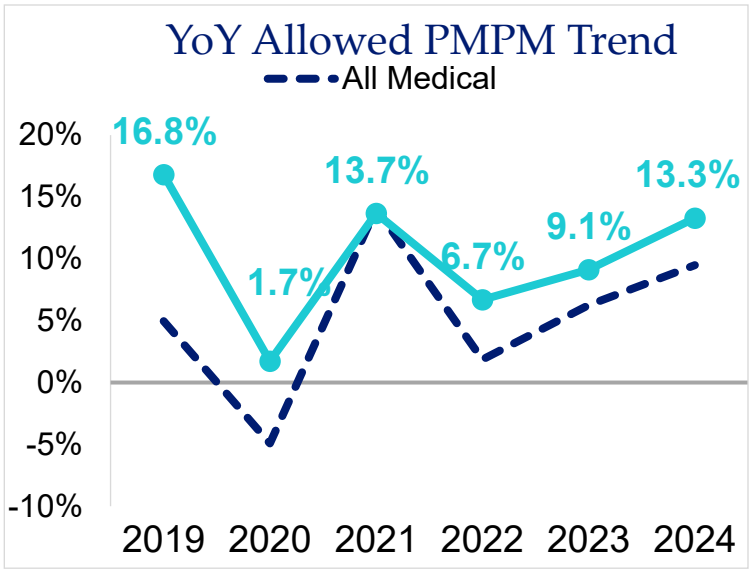
Source: SHAPE Data Warehouse; Historical trend represents annualized trend from CY 2018 – CY 2019

Focus Area: Mental Health

Prevalence and Cost Trends







- Mental health has been a major medical trend driver for several years and was one of the few areas that did not see a reduction in costs in 2020. Despite the pandemic waning, utilization continues to drive overall cost trends.
  - 30.4% of individuals had a mental health claim in 2024, up from 28.4% in 2023. Mental health costs PMPM increased 13.3% during that time.
- There have been double digit trends for treatment of autism, attention-deficit hyperactivity disorders (ADHD), trauma & stress, anxiety, and other neurodevelopmental disorders.

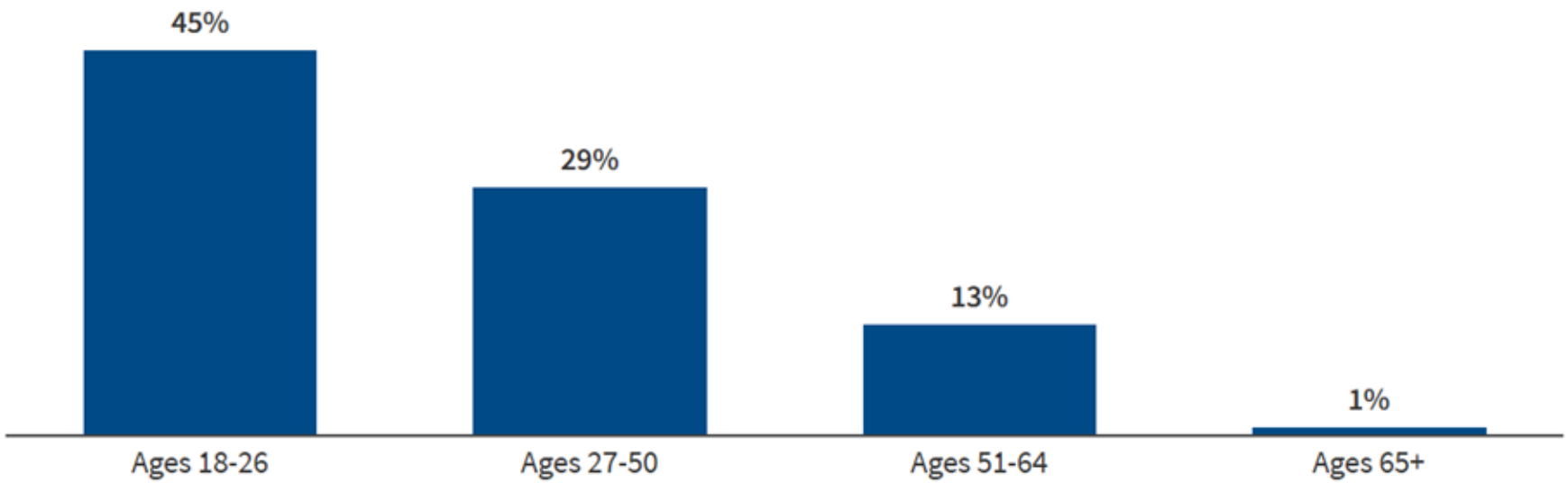
Source: SHAPE Data Warehouse

Focus Area: Mental Health

Figure 2

Adults Ages 18-26 Experienced the Largest Increase in the Share Reporting Use of Mental Health Services from 2019 to 2022

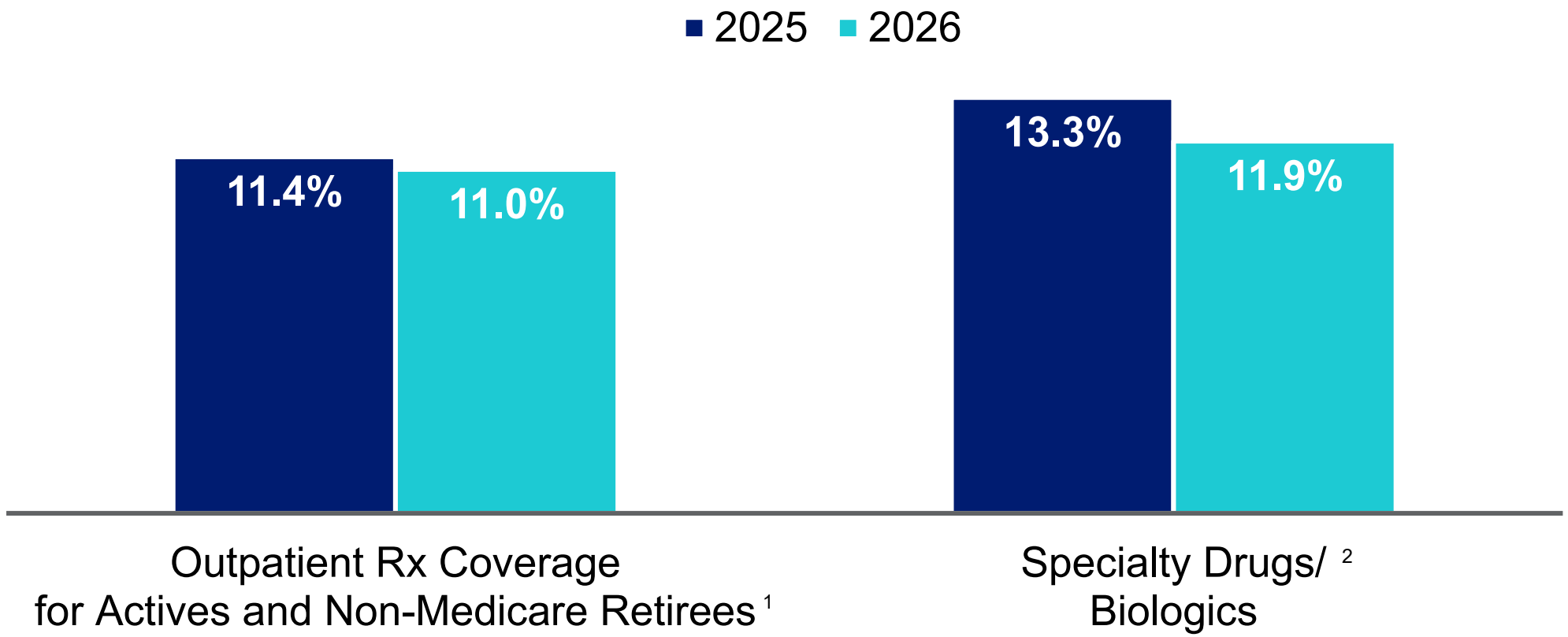
Growth Over Time | Share Receiving Services, By Year



The share of retirees utilizing mental health services trails other population segments despite their risks of higher rates of depression, anxiety, substance use, social isolation, and other behavioral health needs associated with aging, chronic conditions, caregiving responsibilities, life transitions, and financial stress.

Source: Kaiser Family Foundation, Exploring the Rise in Mental Health Care Use by Demographics and Insurance Status, 8/1/2024

Projected Prescription Drug Trends: 2025 and 2026



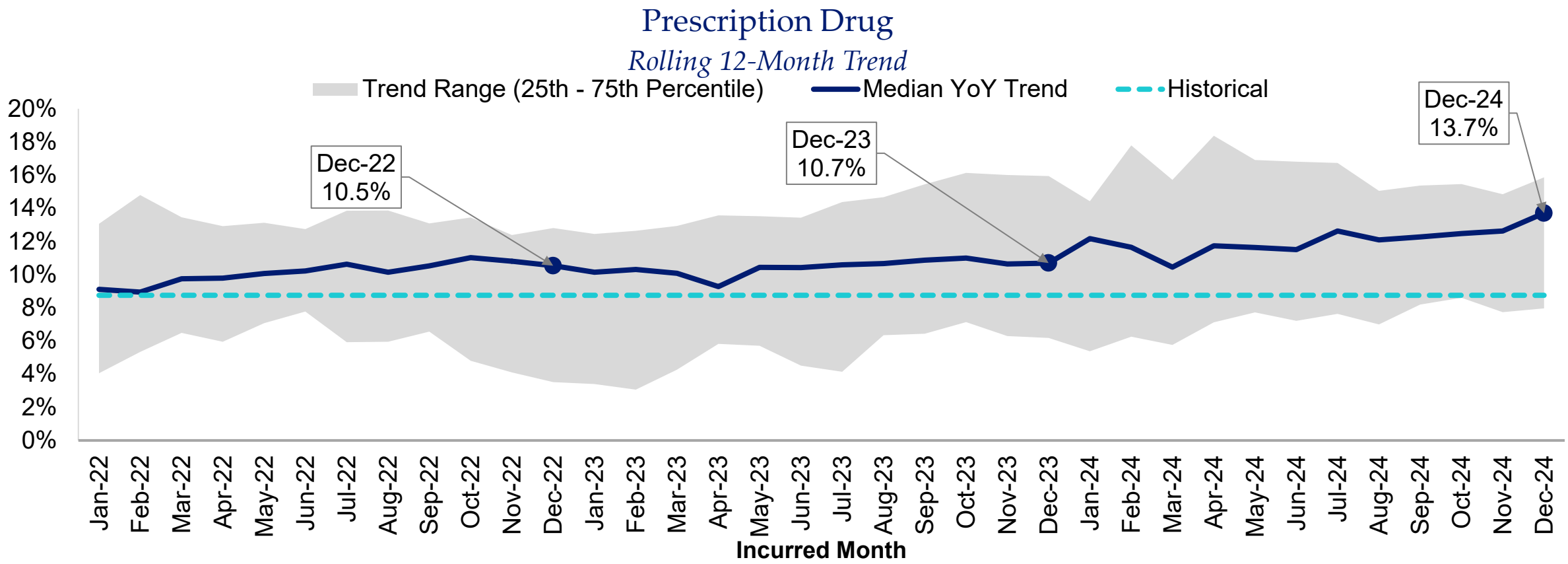
Source: 2026 *Segal Health Plan Cost Trend Survey*

[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

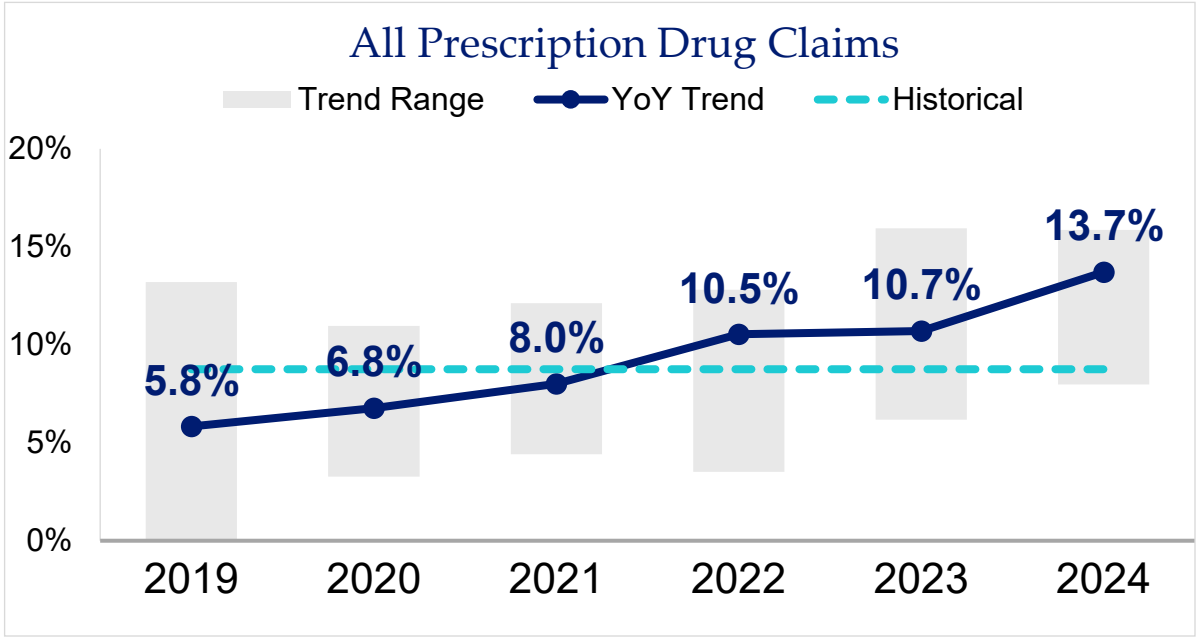
% Change in Allowed PMPM

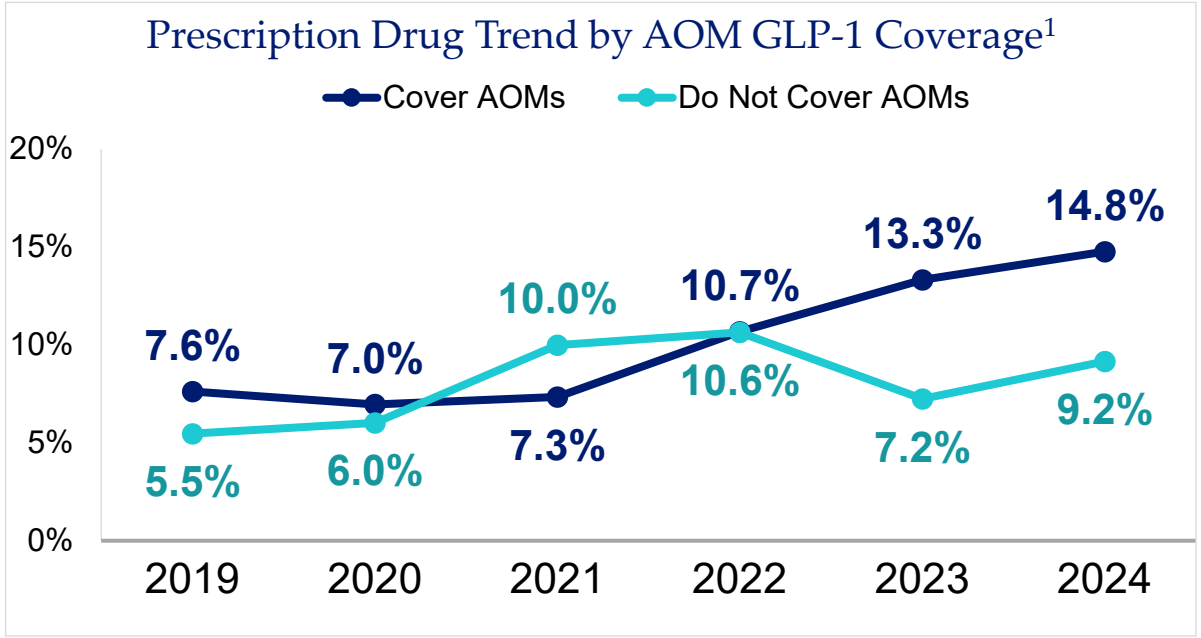


Source: SHAPE Data Warehouse; Historical trend represents annualized trend from CY 2018 – CY 2019

Prescription Drug Trend Summary – GLP-1s

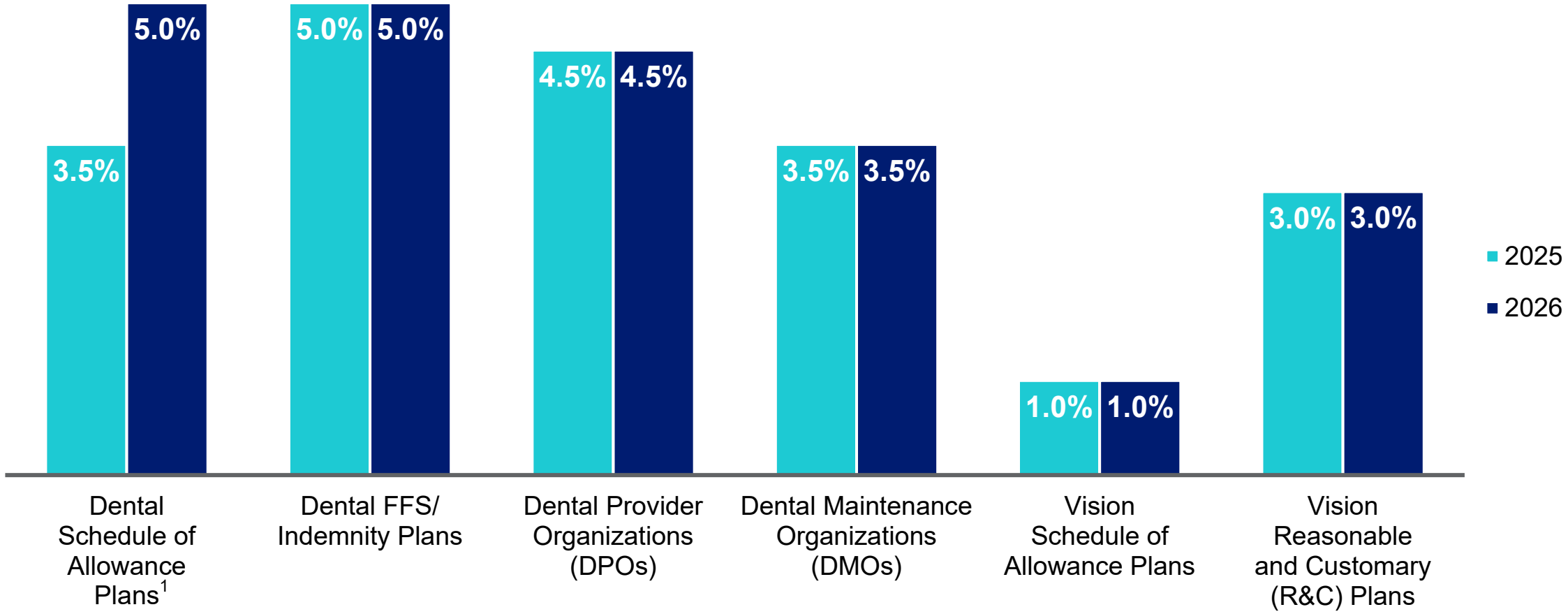
% Change in Allowed PMPM





Source: SHAPE Data Warehouse; Historical trend represents annualized trend from CY 2018 – CY 2019

Projected Dental and Vision Trends: 2025 and 2026



Source: 2026 *Segal Health Plan Cost Trend Survey*

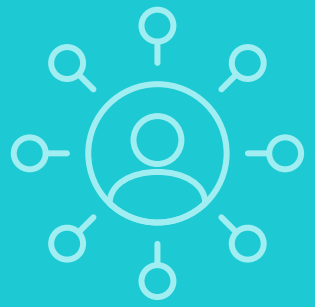
[1] A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan.

Strategies for Managing Medical and Pharmacy Benefit Costs

Top Medical Cost-Management Strategies

Digital Health Coaching

Well-being Services



Narrow Networking Strategies

Use of AI (detect fraud, improve outreach)

Out-of-network Cost Management Negotiations

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

Anthem

Our foundational mental health support for members

Screenings and data analysis
to identify at-risk members who may need co-management of their health conditions

Follow-ups after hospitalization
and readmission; predictive modeling to help members avoid repeat hospital stays

Emotional Well-being Resources
that deliver emotional health support based on a digital cognitive behavioral therapy approach*

Comprehensive Case Management
services and outreach to help members and their families manage and cope with hospitalizations, eating disorders, autism spectrum disorder, and other issues

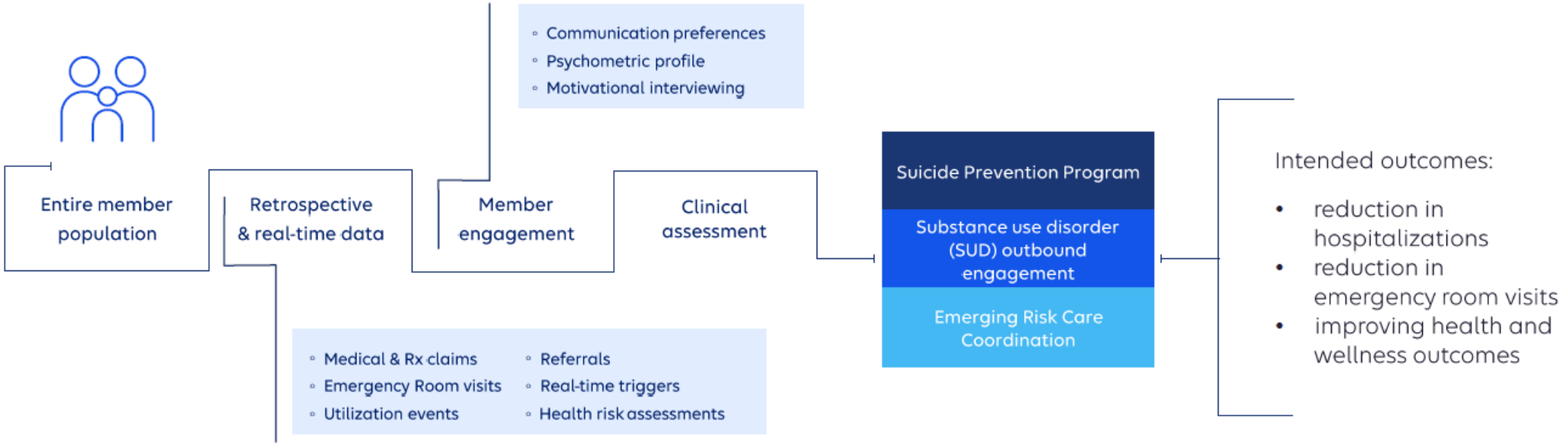
Targeted engagement
for suicide prevention, emerging-risk care coordination, and predictive modeling to support members who are at risk of experiencing negative health outcomes related to substance misuse

* Emotional Well-being Resources applies to Large Group fully insured and administrative services only (ASO) accounts with Behavioral Health Case Management.

11

Anthem

How does predictive modeling get ahead of crisis health events



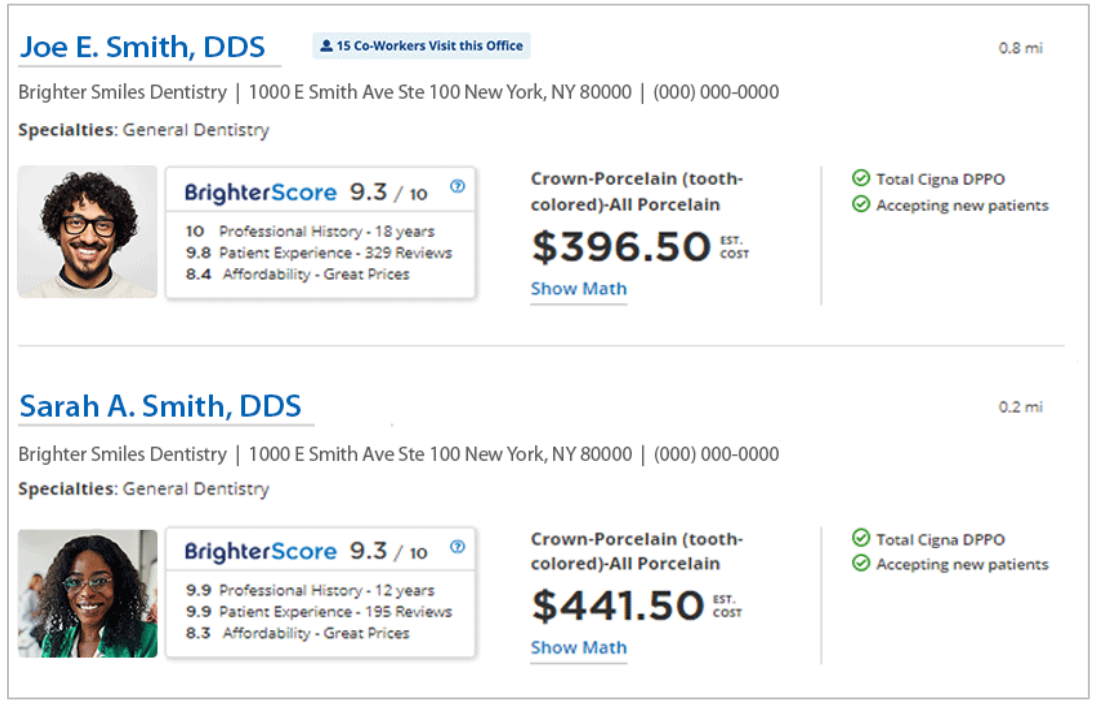
Predictive modeling identifies and stratifies employees at risk of opioid and alcohol-related negative health outcomes over the next 12 months and triggers intervention for those in critical risk.

12

Activate the full power of your dental plan with myCigna

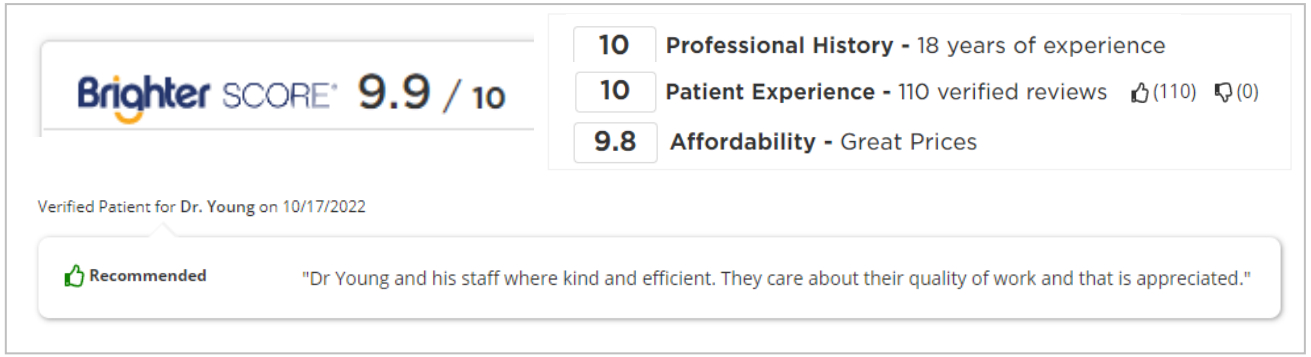
myCigna® empowers customers to find the right care when, how, and where they need it most

Plan- and dentist-specific costs shows customers what they'll pay before they go to the dentist



Brighter Score® makes it easy to find high-value network providers based on individual needs

Verified Customer Reviews let customers hear from other patients.



myCigna helps customers save money

99.7%
of customers who use myCigna stay in-network*

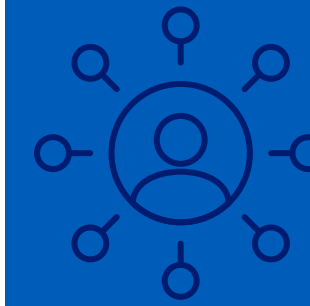
$117
more savings PMPY vs customers who don't use myCigna*

Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
*Internal reporting as of November 2021 for DPPO customers who use myCigna and customers who do not use myCigna. All images used for illustrative purposes.

Top Rx Cost Management Strategies

Effective Clinical Controls

Specialty Cost Management/ Biosimilars



Strategies for GLP-1s

Most of these cost-management strategies will be relevant for 2026 and beyond.

Top Rx Cost Management Strategies

Utilization Management

- Comprehensive Utilization Management Edits:
  - Prior Authorization (PA)
  - Quantity Limit (QL) rules based on FDA guidelines
- Treatment protocols based on best clinical practices/Tiering Strategy

Formulary Management

- Standard Control Formulary (SCF) Opt-In (mandatory drug exclusions up to quarterly)
  - Narrow, highly managed formulary to prefer least costly drug alternatives
- Advanced Control Specialty Formulary (ACSF)
  - Specialty Guideline Management (SGM) : PA required for all specialty drugs
- Management of New-To-Market drugs
- Formulary Exclusions

Clinical Programs

- Drug Savings Review
- Pharmacy Advisor Counseling
- Accordant Care Program for Rare/Complex Diseases

Top Rx Cost Management Strategies

- Promotion of Biosimilars
  - Tiered plan design that offers lower member costs when taking biosimilars
  - Updated formularies that include biosimilars as the preferred option
  - Utilize PA to direct providers and members toward biosimilars, if available and appropriate
  - Facilitate biosimilar adoption by covering interchangeable biosimilars, which, like
    generic drugs, can be switched by pharmacists 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 excluding coverage for the originator product
  - 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

Top Rx Cost Management Strategies
Stelara Biosimilars

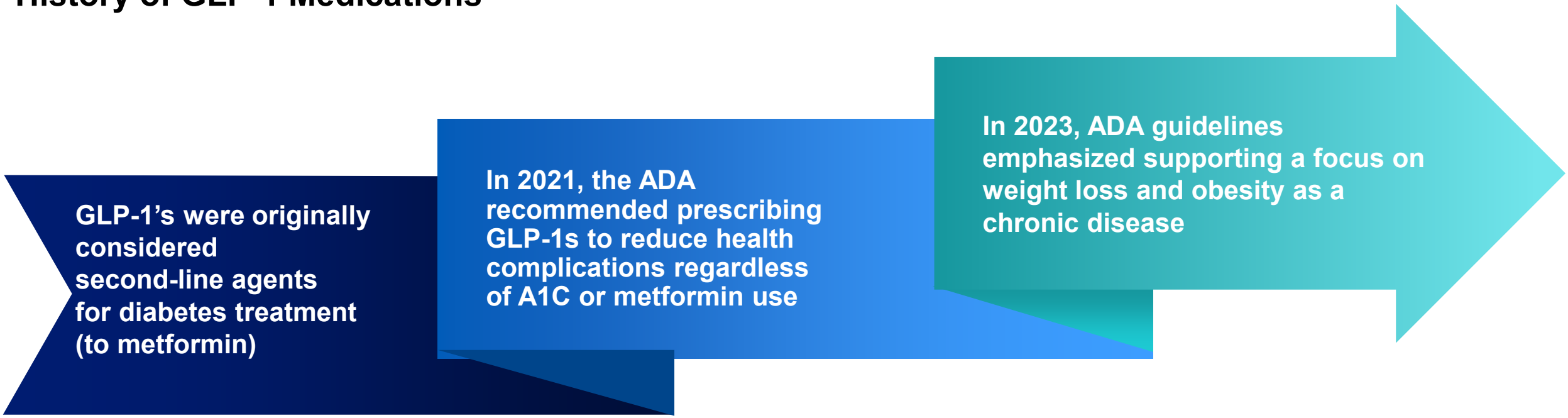
As of late 2025, there are eight FDA-approved biosimilars to Stelara. These biosimilars have significantly lower list prices; roughly 85% less than the original brand. The medications have equivalent safety, efficacy, and FDA-approved indications, with several designated as interchangeable. The products below are designated as interchangeable, meaning they may be substituted for Stelara by a pharmacist without requiring a new prescription from the prescriber:

- **Wezlana** (ustekinumab-auub): Approved by the FDA as the first interchangeable biosimilar for all Stelara indications.
- **Selarsdi** (ustekinumab-aekn): Approved as an interchangeable biosimilar with a launch date of early 2025.
- **Otulfi** (ustekinoumab-aauz): Designated as an interchangeable biosimilar.

As of July 1, 2026, CVS will prefer interchangeable biosimilars and exclude brand Stelara from the formulary. Per CVS, the change will impact 16 members and may result in up to $155 million in annual net savings to LACERA.

Top Rx Cost Management Strategies

History of GLP-1 Medications



In response to the increased utilization of GLP-1s, LACERA adopted CVS's Smart-Logic PA edit on July 1, 2023, to ensure appropriate utilization for diabetics-only. The edit was updated by CVS on July 1, 2025, and is credited with $2.8M in savings.

CVS AccordantCare

24/7 nurse support

Taking care of a complex condition can be hard. Support from nurses who know your condition can help you live your best life. Once you get started, you can use the program as much or as little as you like. We're here for you — on your terms.

Led by a medical director and doctors who are recognized nationwide

We offer care and support for:

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- Crohn's Disease
- Cystic Fibrosis
- Dermatomyositis
- Epilepsy
- Gaucher Disease
- Hemophilia
- Multiple Sclerosis
- Myasthenia Gravis
- Parkinson's Disease
- Polymyositis
- Rheumatoid Arthritis (RA)
- Scleroderma
- Sickle Cell Disease
- Systemic Lupus Erythematosus (SLE or Lupus)
- Ulcerative Colitis

As a member of our program, we hope you will:

- √ Follow the care plan we design with you
- √ Provide us with the information we need to help you
- √ Tell us and your doctor if you do not want to be in our program

You have the right to:

- √ Know about our program and the services we offer
- √ Know the name and experience of the nurse or other staff who help you manage your care
- √ Share in making choices about your health
- √ Be treated in a kind way
- √ Ask for a new nurse team or speak to a manager at any time
- √ Have your personal and health information stay private and safe
- √ Know what we do to keep your information private and who can see it
- √ Decide not to be in our program
- √ Know about your health, your disease and your treatment options and discuss all options with your doctors
- √ Get information that is right and easy to read
- √ Know how we work with other companies and your health plan
- √ Know when we are open each day
- √ Tell us what you like about our program at any time
- √ Complain about our program in writing and get a response in 15 working days

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Accordant® CVS specialty nurse care management

Accordant® CVS specialty nurse care management

LACERA

The care and support you need — on your terms

AccordantCare® for complex conditions is part of your benefit plan. It's at no extra cost.

Accordant.com

Thank You

Biographies

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.

Educational background

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).

Stephen E. Murphy, CEBS

Senior Vice President and Benefits Consultant, Los Angeles

Expertise

Steve is a Senior Vice President and Benefits Consultant in Segal's Los Angeles office with more than 35 years of health benefits experience. He works with state, city and county governments as well as other public sector clients to develop and maintain their employee benefit plans. Steve has specialized expertise in health strategy development and implementation, claim reporting and data analysis, and vendor evaluation, selection and management.

Educational background

Steve holds a BS in Business Administration from the University of Southern California and a MS in Human Resource Management from Boston University. He is a Certified Employee Benefits Specialist and holds a certificate in Global Business Management from the International Foundation of Employee Benefit Plans.

Michael Szeto

Senior Actuarial Associate

Expertise

Michael is a Health Benefits Analyst in Segal's Los Angeles office. With nearly 10 years of experience, he analyzes health plan data and prepares financial reports including renewal analysis and plan pricing projections.

Educational background

Michael received his BBA from Temple University with a major in Actuarial Science. He is taking exams offered by the Society of Actuaries and has obtained a California Life Agent License.

RETIREE HEALTHCARE

Overview of Fiscal Operations

CASSANDRA SMITH
Retiree Healthcare Director

TED GRANGER
Chief Financial Officer

Agenda

Five sections covering the operational core of the RHC Program.

01

Executive Summary

Overview of RHC Program and Next Steps

02

Document & Formalize Annual Process

Memorialize the annual workflow with the County Plan Sponsor.

03

Premium Renewals & Budgeting

Annual renewal cycle and Administrative Fee review.

04

Financial Accounts

Seven accounts spanning ~$6.1B in program assets.

05

Financial & Actuarial Reporting

Reporting cadence, governance, and the path forward.

Executive Summary

Five themes that define the Retiree Healthcare Program.

01 Program Foundation

Under the 1982 Agreement, LACERA administers the Retiree Healthcare Benefits Program on behalf of Los Angeles County for eligible retired members, survivors, and dependents.

02 Premium Renewals & Budgeting

Insurance premium renewals, administration costs, and OPEB Trust budgets are reviewed annually with the County during January/February meetings.

03 Financial Accounts

Six Primary accounts supporting program operations: OPEB Trust ($5.8B), Premium Reserves ($199M), Federal Funds ($62.5M), Premiums ($14M), Administrative Fee ($13.6M), and Checking ($697K).

04 Reporting & Governance

A comprehensive cycle includes actuarial valuations, GASB 75 reports, SOC-1 audits, and audited financial statements with Board oversight.

05 Looking Ahead

Future topics include transitioning to single-stream funding, reaching the Actuarially Determined Contribution, refining the administrative fee review process, and continuing the discussions regarding the Lifetime Maximum Benefit.

~$6.1B
TOTAL ASSETS

1982
FOUNDATIONAL AGREEMENT

7
PARTICIPATING EMPLOYERS

44
YEARS SINCE 1982 AGREEMENT

Business Process Model

Anchored by the 1982 Agreement and 1994 Amendment.

LACERA'S ROLE

***RHC** administers the Los Angeles County Retiree Healthcare Benefits Program for eligible LACERA retired members, survivors, and their eligible dependents.*

1982 AGREEMENT

Plan Sponsor Acknowledgment

Los Angeles County (Plan Sponsor) and LACERA acknowledge the 1982 Agreement and 1994 Amendment.

APPOINTMENT

Program Administrator

LACERA appointed as the Retiree Healthcare Benefits Program administrator on behalf of the County.

FUNDING

County Subsidy

County agreed to fund the retiree healthcare premium subsidy for eligible members and dependents.

1994 AMENDMENT

Amendment

Los Angeles County (Plan Sponsor) agreed to continue funding the retiree healthcare program administered by LACERA, regardless of changes to or cancellation of the County's active employee benefits programs.

Annual Workflow with Plan Sponsor

Annual meetings with the LA County CEO Office — current scope and proposed additions.

EXISTING COMPONENTS

- Insurance Premium Renewals
- Lifetime Maximum Benefit limit discussion
- Budgeting Process
- Financial Accounts Review
- Financial and Actuarial Reporting

PROPOSED ADDITIONS

OPEB Trust and Investment Review

Strategic asset allocation, cash and funding requirements.

Program / Reporting Updates

Program-level changes; financial and actuarial reporting modifications.

Program Funding Updates

Single-stream funding, ADC progress, OPEB Funding Policy.

NEXT STEPS | MEMORIALIZE· *Annual discussion, process and procedures (plan sponsor expectations, update the annual process, review timelines and dates, include additional information) to ensure continued effective management of the RHC Program throughout future years.*

Annual Renewal Timeline

From proposed renewals to effective date — September through July 1.

SEP-OCT	NOV-DEC	JAN	FEB	MAR	APR-JUN	JUL 1
Proposed Renewals	**Review & Counter**	**Negotiation**	**IBLC Review**	**BOR Approval**	**Implementation**	**Effective**
Healthcare consultant requests proposed renewals from health plans for next fiscal year.	Consultant reviews renewals; LACERA submits counter-proposal and receives modified renewals.	Full-day carrier meetings; final renewal report delivered for IBLC.	Present final negotiated renewal report to Insurance, Benefit, and Legislative Committee.	Board of Retirement approves the upcoming fiscal year renewal report.	Communication plan and rate implementation with County and Member Operations.	New renewal rates go into effect for the new fiscal year.

RHC & OPEB Trust Budgeting

Two budget tracks — Administrative Fee and OPEB Trust expenses.

TRACK 01

ADMINISTRATIVE FEE

RHC Budgeting

- Milliman annually projects RHC Division revenue, expenses, and per-member fee.
- Historical and projected data inform the annual budget.
- Account balance monitored to ensure fiscal stability.
- Fee changes evaluated each January/February with the County.

TRACK 02

OPEB TRUST

OPEB Trust Budgeting

- Estimated administrative and non-administrative expenses reported in April.
- Actuals reported to County, Superior Court, and LACERA in November.
- Cost allocation percentages reviewed annually for equitable distribution.
- Annual budget meetings with the County in January/February.

RHC Accounts Overview

Seven accounts spanning approximately $6.1 billion in program assets.

~$6.1B — TOTAL ACCOUNT BALANCES · *Approximate balances as of March 2026 across seven RHC accounts.*

OPEB TRUST
$5.8B
Pre-fund OPEB costs; County, Superior Court, LACERA.

RESERVES
$199.2M
Healthcare premium surpluses and deficits.

FEDERAL FUNDS
$62.5M
.

PREMIUMS
$14.0M
Collect & pay insurance premiums.

ADMIN FEE
$13.6M
$8/month per member; funds RHC operations.

CHECKING
$697K
RHC Division administrative expenses.

LACERA HEALTH
$420K
County trust — monthly OPEB pay-as-you-go.

Consistent reporting is delivered monthly to ensure transparency.

Reporting Responsibilities

Distinct roles ensure fiduciary oversight and operational accuracy.

BOARD ROLE

Fiduciary Oversight

- Approve OPEB actuarial valuation and triennial experience study.
- Provide oversight of retiree healthcare and OPEB funding policies.
- Receive SOC-1 Type 2 reports through the ACRE Committee.
- Receive audited financial and actuarial reports.
- Monitor reporting cadence and oversight structure.

MANAGEMENT ROLE - FASD

Operational Execution

- Coordinate preparation of actuarial valuations and studies.
- Implement Board-approved assumptions and funding policies.
- Maintain internal controls over OPEB financial reporting.
- Prepare financial, actuarial, and regulatory reports.
- Manage day-to-day RHC accounts, trust funds, and reporting cycles.

RHC Reporting Overview

Deliverables, governance, and cadence — mirroring Pension Fund reporting.

DELIVERABLE	GOVERNANCE / OVERSIGHT	CADENCE
OPEB Program — Actuarial Valuation	*Consulting actuary; BOR approves*	**Annual**
OPEB Program — Triennial Experience Study	*Consulting actuary; BOR approves*	**Triennial**
Audit of OPEB Experience Study & Valuation	*Auditing actuary; BOR approves*	**Triennial**
GASB 75 Employer Report & Audit	*Consulting actuary; auditing actuary*	**Annual; audit odd years**
OPEB Trust — Schedule of Changes in Fiduciary Net Position	*LACERA staff; external auditor*	**Annual (April)**
SOC-1 Type 2 Audit Report	*External auditor; ACRE Committee*	**Annual (March)**
LACERA AFS & ACFR	*LACERA staff; external auditor*	**AFS Oct / ACFR Dec**

Annual Reporting Calendar

When key deliverables hit the Board, the County, and external stakeholders.

JAN-FEB

- County budget meetings
- Admin Fee policy review
- OPEB Trust strategic plan

MARCH

- BOR Renewal Approval
- SOC-1 Type 2 to ACRE
- Draft Actuarial Valuation

APRIL

- GASB 75 Employer Report
- Schedule of FNP audited
- BOR Triennial approvals

JULY

- New renewal rates take effect
- Fiscal year begins

OCTOBER

- Audited AFS to Boards
- AFS to ACRE & County

NOVEMBER

- OPEB Trust actuals reported
  - County
  - Superior Court
  - LACERA

DECEMBER

- Draft Triennial Study
- ACFR to Boards & County

Strategic Future Initiatives

Five parallel tracks shaping the next chapter of the RHC Program.

01 Single-Stream Funding

Combine the County's monthly pay-as-you-go costs with quarterly OPEB Trust contributions into one payment stream.

02 Actuarially Determined Contribution

The County is on track to meet the ADC in coming years — representing the minimum contribution amount to fund the Program.

03 Administrative Fee Review

Establish a more formal process for fee evaluation in coordination with the County.

04 OPEB Funding Policy

Preliminary conversations underway to formalize a written policy document.

05 Lifetime Maximum Benefit (LMB)

Continue the discussion to eliminate benefit ceilings.

Key Takeaways

What the RHC Program delivers — and what's next.

01 Foundation Anchored in 1982

LACERA administers the Retiree Healthcare Benefits Program for Los Angeles County under a longstanding agreement and amendment.

02 ~$6.1B Across Seven Accounts

Coordinated management of OPEB Trust, Premium Reserves, Federal Funds, and operating accounts ensures program sustainability.

03 Predictable Annual Cadence

Premium renewals, budgeting, and reporting follow a documented annual cycle with clear roles and dates.

04 Path to Full Funding

Single-stream funding, ADC progress, and a formal OPEB Funding Policy strengthen the program's long-term trajectory.

Thank You

Questions and discussion welcome.

Segal

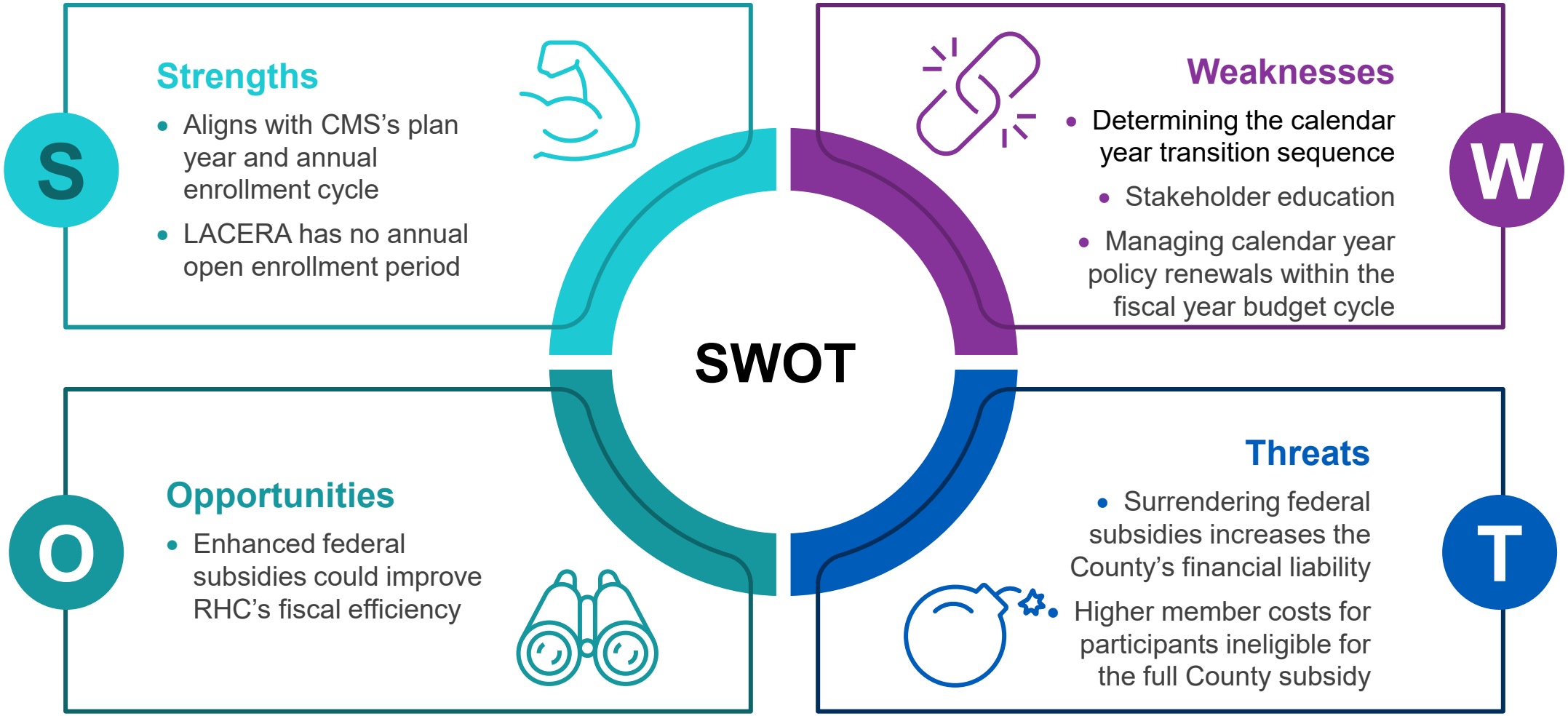
LACERA

SWOT Analysis

Retiree Healthcare: Transitioning From a Fiscal to a Calendar Plan Year

May 19, 2026, Cassandra Smith, LACERA / Stephen Murphy, Segal

Retiree Healthcare: Transitioning to a Calendar Plan Year



Strengths

Medicare Enrollment Periods

Initial Enrollment Period

3 months before your 65th birthday and 3 months after

Enroll in Part A, Part B, Part D, and Medicare Supplement or Medicare Advantage Plan for the first time

Annual Enrollment Period

October 15 – December 7

Change, drop or enroll in Medicare Advantage plan and Part D plan

Open Enrollment Period

January 1 – March 31

Change or drop an existing Medicare Advantage plan

General Enrollment Period

January 1 – March 31

Enroll in Part A or Part B if you missed your IEP

Special Enrollment Period

Lasts for up to 8 months

After employment coverage ends – you can enroll in Part A and Part B, then in Medigap + Part D or Medicare Advantage

LACERA Enrollment Process

LACERA has no Annual Enrollment period

After Retirement

Within 60 days from your retirement date or your retirement board letter[1]

Plan Changes

Subject to a six (6) month waiting period following LACERA's receipt of your completed and signed enrollment form

Adding Eligible Dependents

LACERA must be notified within 30 days of a qualifying event (e.g., marriage, registration of domestic partnership, birth, or adoption)[1]

[1] Late enrollments are subject to a six-month waiting period for medical coverage and a 12-month waiting period for dental coverage.

Weaknesses

Weaknesses –

Transition, Education, Renewals

1

Determining the calendar year transition sequence
An initial six-month contract bridges to a calendar year basis more quickly while an initial 12-month contract provides more time to prepare stakeholders for the transition.

Stakeholder Education
Participants may have concerns with rate changes during the six-month bridge to a calendar year basis, while LACERA and County staff will need to establish new protocols for managing future fiscal budgets.

2

3

Managing calendar year policy renewals within the fiscal year budget cycle

Multiple public sector entities, including the Cities and Counties of San Diego and San Francisco, manage multiple renewal cycles over their fiscal year.

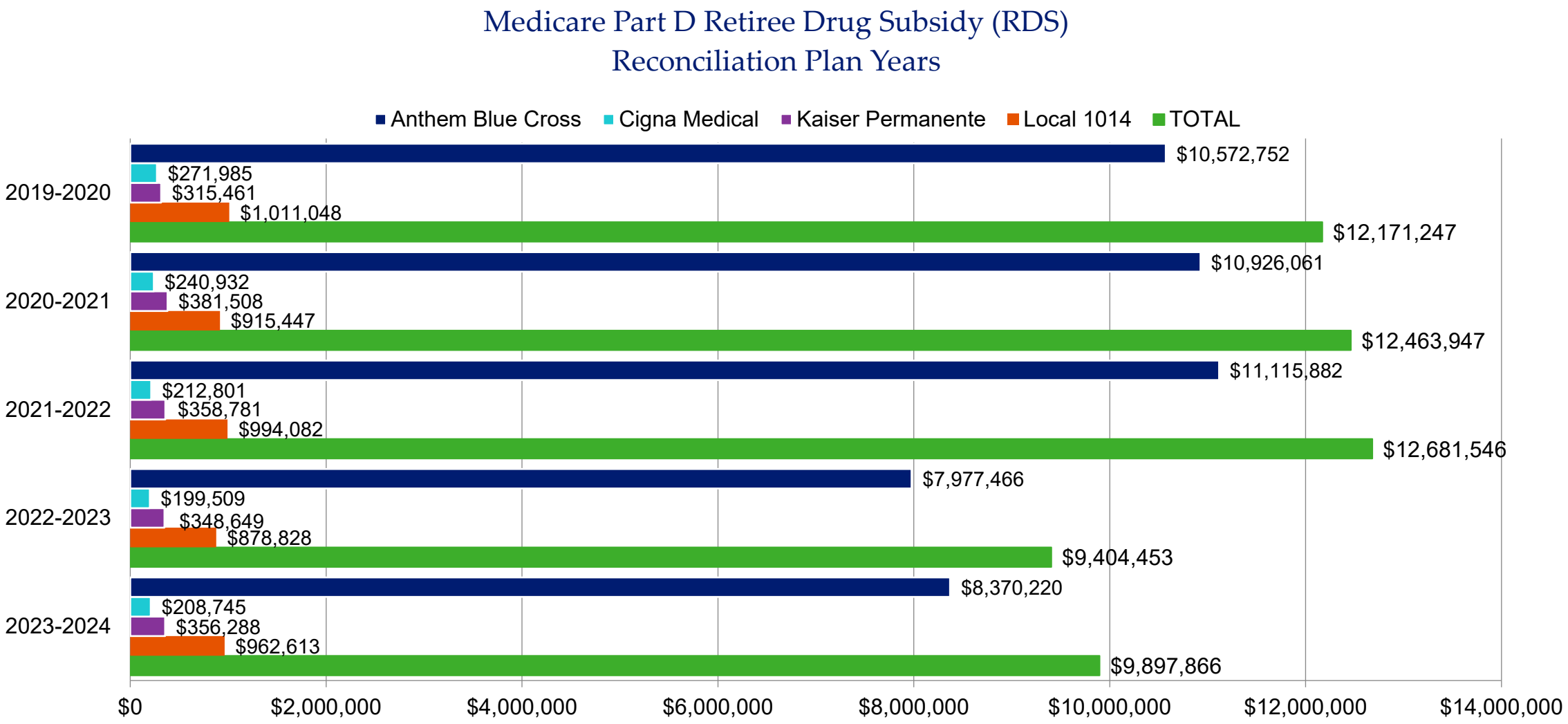
Opportunities

Retiree Drug Subsidy (RDS)

- Program went into effect January 1, 2006, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Reimburses Plan Sponsors for a portion of the costs for prescription drugs between the applicable Cost Threshold and Cost Limit.
- Subsidy is 28% of the *aggregate* amount between the Cost Threshold and Cost Limit (less any manufacturer rebates or similar price concessions)
- There is no calendar plan year requirement

LACERA's Historic RDS Reimbursements

Centers for Medicare and Medicaid Services (CMS)



Employer Group Waiver Plan (EGWP)

- EGWP program also went into effect January 1, 2006
- An EGWP is a group Medicare Part D plan
  - Retirees continue to receive coverage through their group plan, versus an individual Medicare Part D plan sold on a retail basis
- Plan is administered on a calendar year basis through a carrier or PBM
- Enables access to the full suite of Medicare Part D subsidies
  - Direct subsidies
  - Reinsurance
  - Coverage gap discounts
  - Low-income subsidies

RDS v. EGWP

Category	RDS	EGWP
Plan Year Requirement	None	Calendar Year
Federal Funding	28% subsidy only	Multiple Part D subsidies
Rebates	None	High manufacturer rebates
Savings Level	Modest	Typically, 2–4x RDS
Subsidy Timing	Retrospective	Prospective & ongoing
Administration	High	Low
Retiree Impact	Minimal change	Minimal or improved

LACERA's EGWP Assessment

Neither Anthem nor CVS was willing to provide a fully insured quote until CMS releases the 2027 Part D subsidy levels during Q3 2026.

Both Anthem and CVS' self-funded EGWP proposals could generate between 2-4x more savings than the existing RDS arrangement.

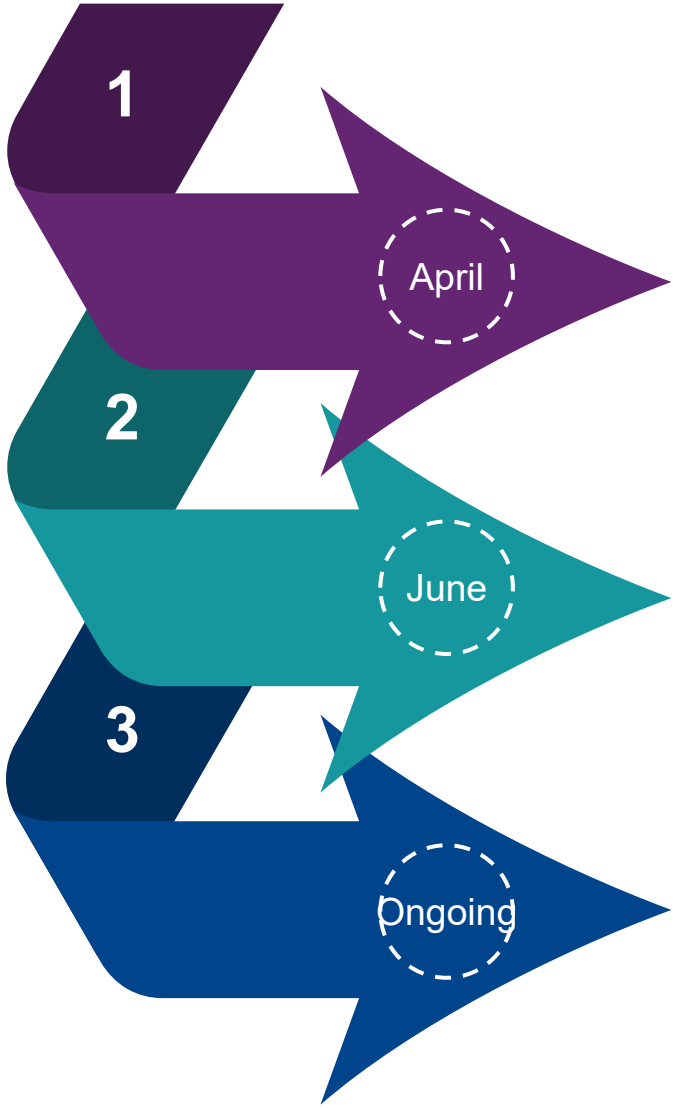
Retail pharmacy access, formulary disruption, and other considerations will be differentiating factors between Anthem and CVS.

Medicare Part C: Medicare Advantage (MA) Plans

- 55% of LACERA's membership are enrolled in a MA plan, which mirrors the national average (54%)[2].
- CMS' capitated payments to MA plans are developed on a calendar-year basis and represent the primary funding source for all MA plans.
- Transitioning LACERA's MA plans to a calendar-year basis will extend the full financial value of CMS' payment factors, incrementally reducing the Kaiser Permanente, SCAN Health Plan, and UnitedHealthcare's MA premium rates.

[2] Medicare Advantage in 2025: Enrollment Update and Key Trends, July 28, 2025, Kaiser Family Foundation, Medicare Advantage in 2025: Enrollment Update and Key Trends | KFF

Medicare Part C: MA Plans' Rate Development Cycle



CMS announces base capitation rates/benchmarks for the following calendar year (e.g., 1/1/2027).

MA organizations submit bids
CMS uses the bids plus the previously announced rates/benchmarks to set the plan's payment amounts for the upcoming year.

Monthly capitation disbursements
CMS updates payments based on enrollee risk adjustments and enrollment information.

Threats

Threats –

County vs. Member Impact

County Impact

Surrendering available CMS subsidies by maintaining a fiscal plan year increases the County's financial liability.

Member Impact

Not leveraging available CMS subsidies increases participant costs.

- Members ineligible for the full County subsidy.
- Tier 2 members responsible for dependent coverage premiums.

Segal

LACERA

GLP-1 Panel Discussion

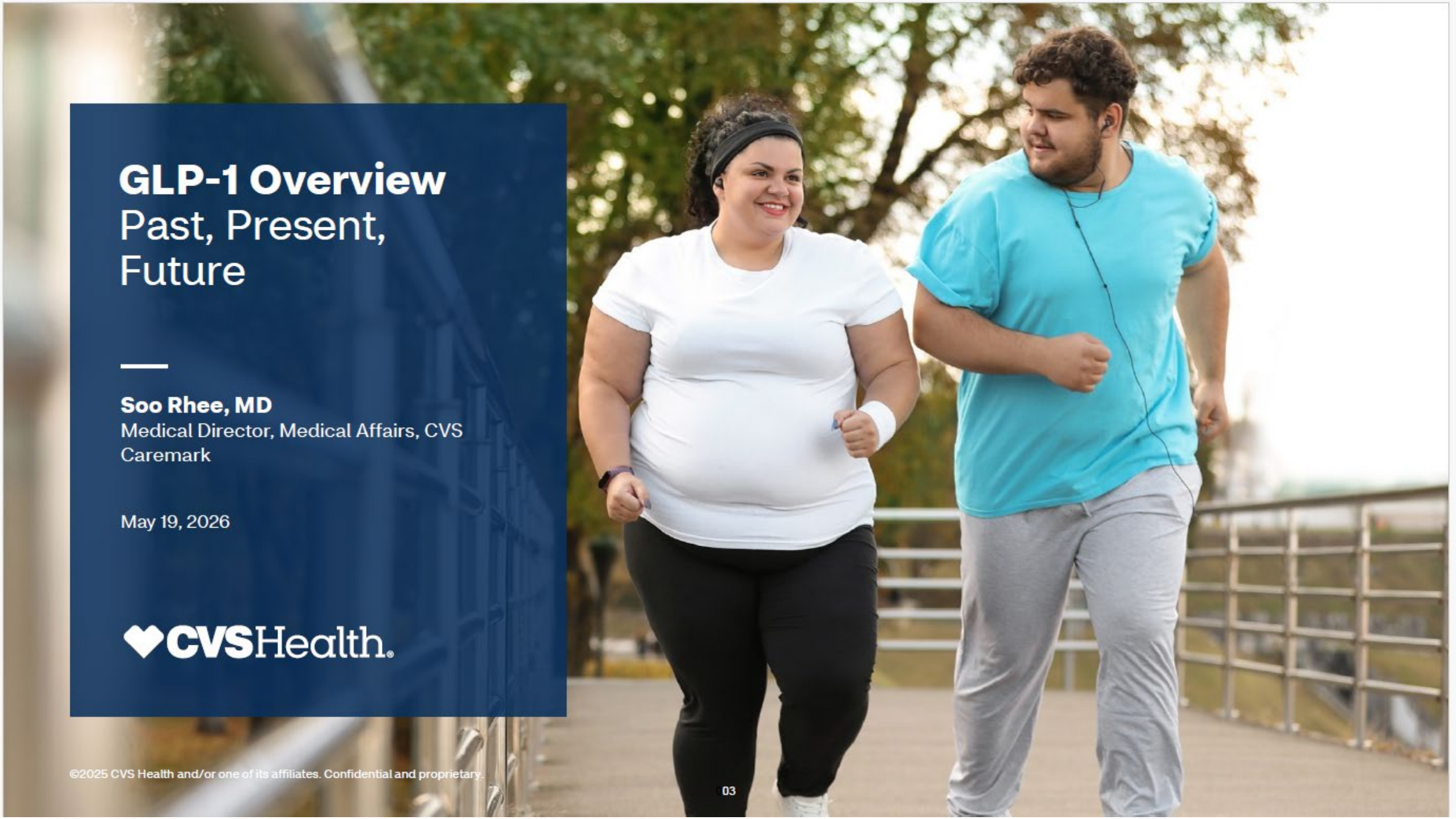
Background, Expanding Clinical Indications, and Regulatory Oversite Impacting Access

May 19, 2026

Panelists: Soo Rhee, MD, CVS, Anthem, Kimberly Petrick, MD, Kaiser Permanente, Joseph Karam, MD,

Moderator: Stephen Murphy, Segal

CVS


GLP-1 Overview
Past, Present, Future
Soo Rhee, MD
Medical Director, Medical Affairs, CVS Caremark
May 19, 2026
CVSHealth.
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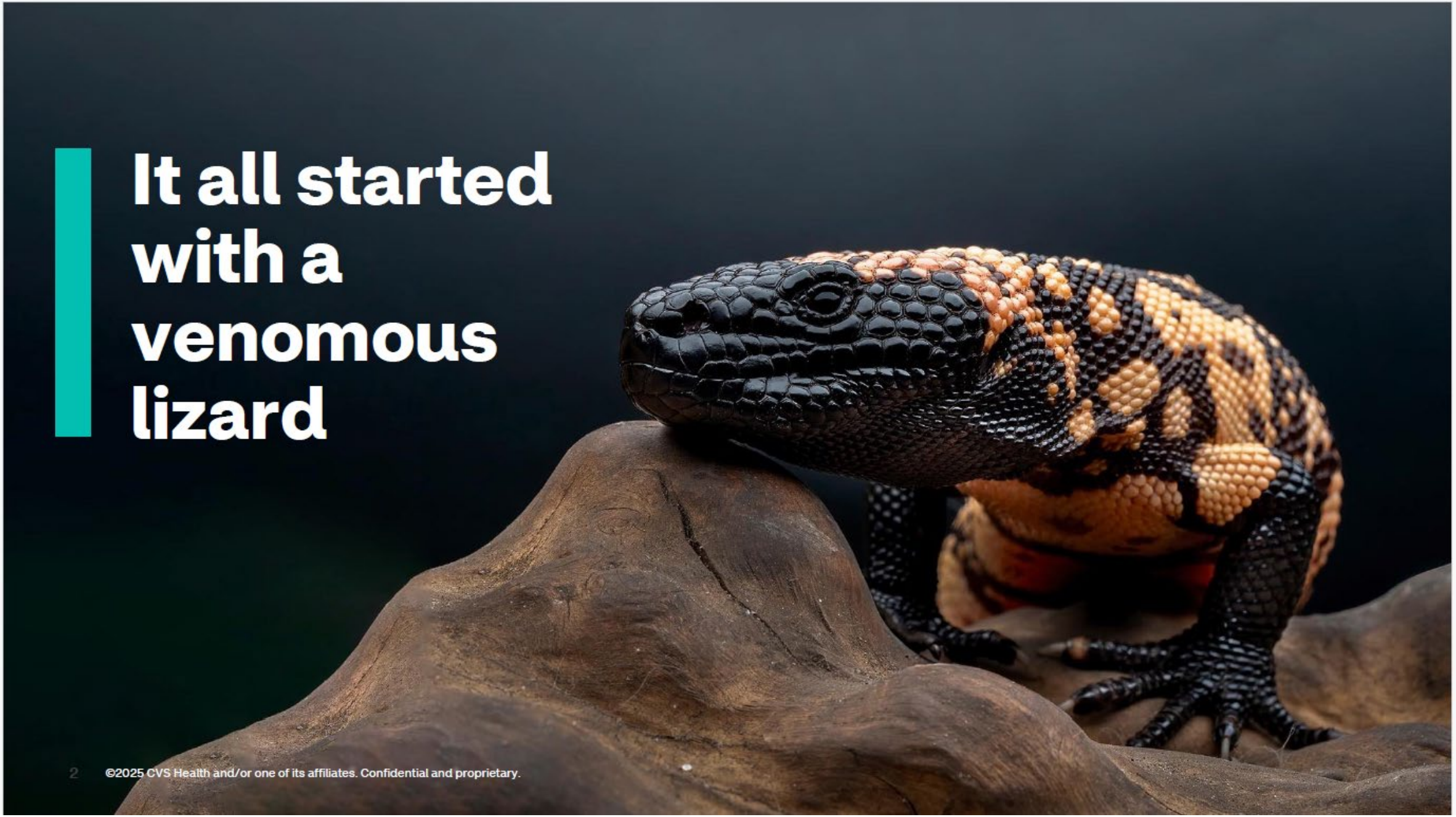
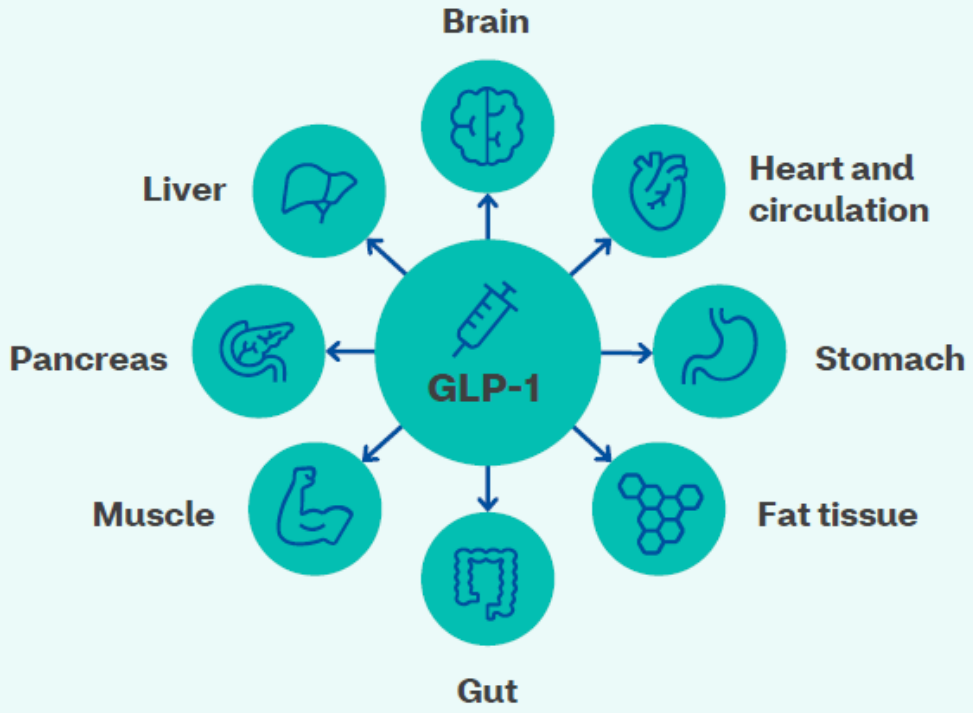
It all started with a venomous lizard



GLP-1 impact on metabolic health

GLP-1s work in many ways:

- Decrease appetite (brain-gut)
- Slow gastric emptying (stomach)
- Increase insulin release and muscle sensitivity to insulin (pancreas, muscle)
- Decrease glucose production (liver)
- Decrease endothelial inflammation (cardiovascular)



Source: Stephanie Kujawski, "The GLP-1 Agonists and Obesity: How Diabetes Drugs are Changing Non-Diabetic Lives," tl;drpharmacy, 5/8/2023. www.tldrpharmacy.com/content/the-glp-1-agonists-and-obesity-how-diabetes-drugs-are-changing-non-diabetic-lives. Accessed 8/30/2024.

Current GLP-1 FDA-Approved Indications

Drug Name	Manufacturer	Dosage form	T2D	Obesity	MASH	OSA	CVRR	CKD
Mounjaro (tirzepatide)	Eli Lilly	Injectable	Approved					
Ozempic (semaglutide)	Novo Nordisk	Injectable	Approved				Approved	Approved
Rybelsus (semaglutide)	Novo Nordisk	Oral	Approved				Approved	
Saxenda (liraglutide)	Novo Nordisk	Injectable		Approved				
Wegovy (semaglutide)	Novo Nordisk	Injectable		Approved	Approved		Approved	
Wegovy 7.2mg (semaglutide)	Novo Nordisk	Injectable		Approved				
Wegovy pill (semaglutide)	Novo Nordisk	Oral		Approved			Approved	
Foundayo* (orforglipron)	Eli Lilly	Oral		Approved				
Zepbound* (tirzepatide)	Eli Lilly	Injectable		Approved		Approved		

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.

OSA: Obstructive sleep apnea
MASH: Metabolic Dysfunction-Associated Steatohepatitis
T2D: Type-2 Diabetes
CVRR: reduction of cardiovascular risk
CKD: Chronic Kidney Disease
OA: Osteoarthritis
IBD: Inflammatory Bowel Disease

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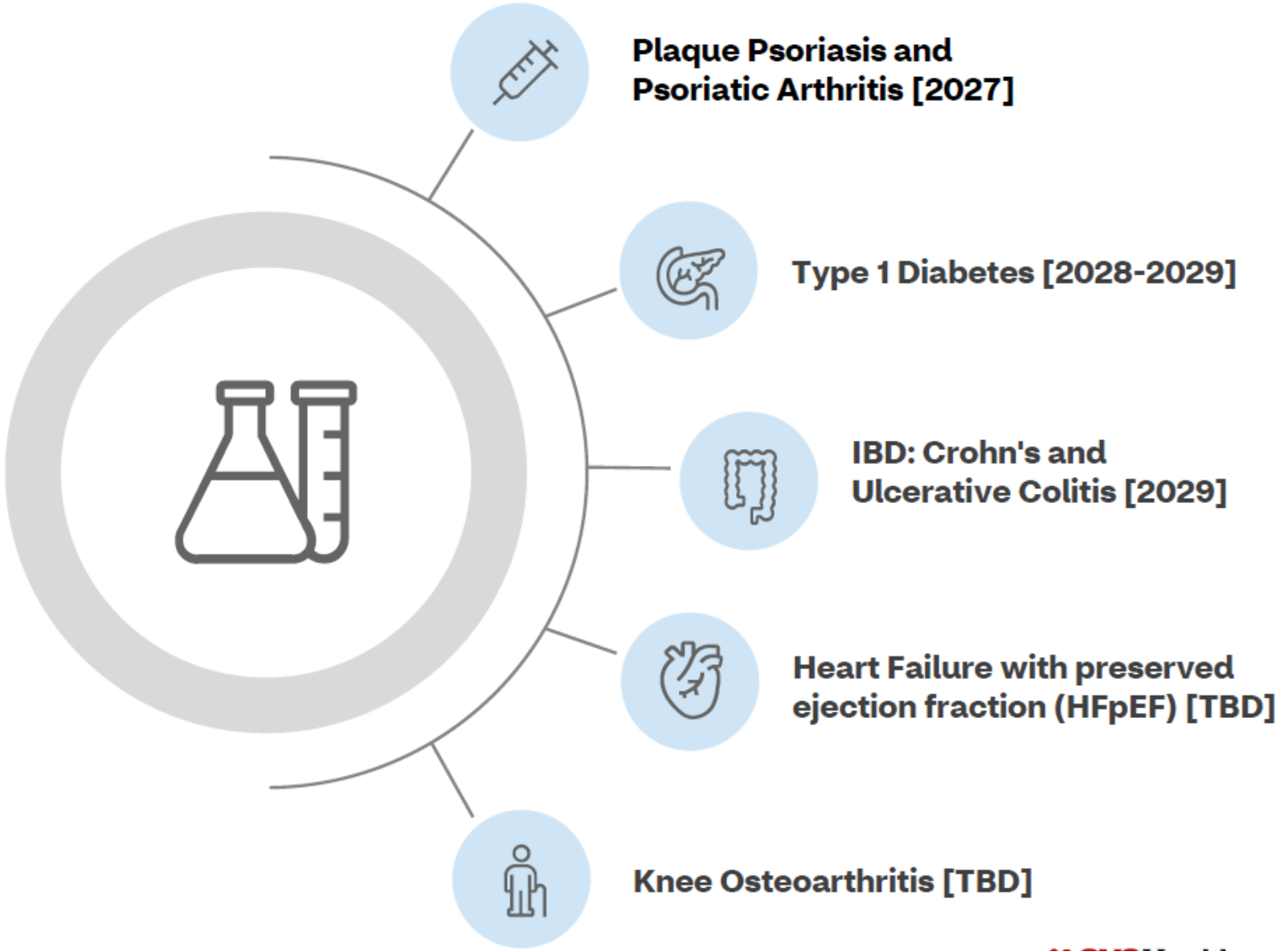
Possible new condition indications *



Dates in brackets indicate first potential approval date. *Source: RxPipeline, Pipeline Services, February 2026.

07

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Currently marketed GLP-1s are being studied in additional conditions*

Drug Name	Manufacturer	Dosage form	T2D	Obesity	MASH	OSA	Diabetic Retinopathy	CVRR	CKD	OA of the Knee	Type 1 Diabetes	IBD	Plaque Psoriasis
Mounjaro (tirzepatide)	Eli Lilly	Injectable	Approved					Q4 2026			Q3 2028		
Ozempic (semaglutide)	Novo Nordisk	Injectable	Approved				Q2 2028	Approved	Approved				
Rybelsus (semaglutide)	Novo Nordisk	Oral	Approved					Approved					
Saxenda (liraglutide)	Novo Nordisk	Injectable		Approved									
Wegovy (semaglutide)	Novo Nordisk	Injectable		Approved	Approved			Approved		TBD			
Wegovy 7.2mg (semaglutide)	Novo Nordisk	Injectable		Q1 2026									
Wegovy pill (semaglutide)	Novo Nordisk	Oral		Approved				Approved					
Zepbound + Omvoh (tirzepatide + mirikizumab)	Eli Lilly	Injectable										Q3 2029*	
Zepbound + Taltz (tirzepatide + ixekizumab)	Eli Lilly	Injectable											2Q 2027
Zepbound* (tirzepatide)	Eli Lilly	Injectable		Approved	2029 or later	Approved		Q1 2029	2029 or later				

OSA: Obstructive sleep apnea
MASH: Metabolic Dysfunction-Associated Steatohepatitis
T2D: Type-2 Diabetes
CVRR: reduction of cardiovascular risk
CKD: Chronic Kidney Disease
OA: Osteoarthritis
IBD: Inflammatory Bowel Disease

*Zepbound is being studied in combination with Omvoh for Crohn's and ulcerative colitis forms of inflammatory bowel disease.

Source: Pipeline Database, accessed April 2026

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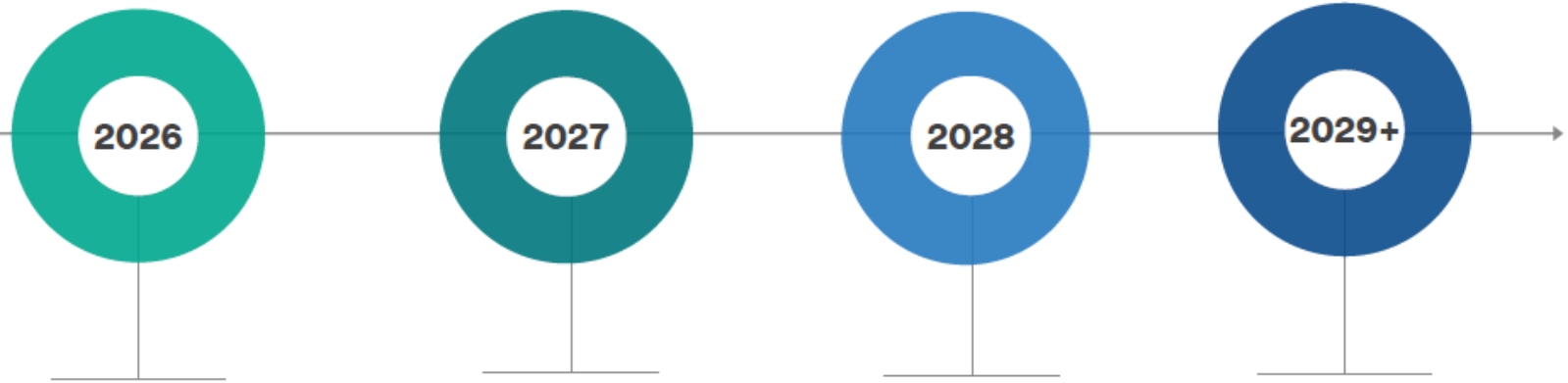
Key Pipeline Events

Numerous new drugs, dosage forms and indications are being developed and studied, shifting the landscape.*



2026

CagriSema for obesity

Orforglipron for obesity^

Mounjaro for CVRR in T2D

Rybelsus for T2D in patients 10-18 years

Saxenda in patients 6-11 years

Wegovy 7.2mg injection^

2027

Cagrisema for T2D

IcoSema

Orforglipron for T2D, CVRR

Retatrutide for obesity, CVRR, MASH, OA

Survodutide for obesity, CVRR

Wegovy for obesity in patients 6-11 years

Zepbound for obesity in patients 12-17 years

Zepbound + Taltz for plaque psoriasis and psoriatic arthritis

2028

MariTide

Mounjaro for T1 diabetes and obesity or overweight

Orforglipron for OSA; obesity in patients 12-17 years.

Ozempic for diabetic retinopathy

Retatrutide for T2D

2029+

Amycretin

Brenipatide

CagriSema for CVRR

Orforglipron for HTN, OA, UI

Pemvidutide

Retatrutide for LBP

Survodutide for MASH

Zepbound for CVRR and in combination with Omvoh for IBD Ulcerative Colitis and Crohn's

Abbreviations:

OSA: Obstructive sleep apnea
HTN: Hypertension
LBP: Low Back Pain
MASH: Metabolic Dysfunction-Associated Steatohepatitis
T2D: Type-2 Diabetes
CVRR: reduction of cardiovascular risk
OA- Osteoarthritis of the knee
IBD: Inflammatory bowel disease
UI: Urinary Incontinence

Blue font indicates new drug/formulation; black font indicates new indication.
^ indicates drug is FDA approved.

*Source: CVS Caremark Pipeline database, accessed April 2026
This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.

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CVS Health's GLP-1 Cost Management Approach:
Customizable Coverage, Cost, and Care Options

Coverage

Plan design
- Category exclusion
- Coinsurance/ copay options

Formulary
- New-to-market review
- Clinical review
- Preferred drug strategies

Effective UM controls

Utilization management (UM)
- Prior authorization (PA)
- Smart Logic PA
- Step therapy
- Quantity limits
- Day 1 UM review

Dedicated, personalized support

Weight management
- Clinical oversight, including member-initiated deprescribing
- Personalized nutrition
- Seamless integration and options

Diabetes management
- Close gaps in care
- Medication oversight and adjustments
- Deprescribing, when appropriate

Additional management strategies are available, including Integrated Fraud, Waste and Abuse and Drug Saving Review.

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Questions

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CVS Health policy statement

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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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Appendix

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Rich pipeline of GLP-1 drugs, combinations and dosage forms

are predicted to yield additional opportunities & drive competition

Drug	Dosage form	Manufacturer	Mechanism of action	Obesity	T2D	CVRR	OSA	Other
Amycretin	Injectable Oral	Novo Nordisk	Amylin receptor agonist/ Glucagon-like peptide-1 (GLP-1) receptor agonist	2029 or later	2029 or later		2029 or later	Osteoarthritis of the knee: 2029 or later
brenipatide	injectable	Eli Lilly	Dual GLP-1 and GIP receptor agonist					Alcohol use disorder: 4Q 2029
CagriSema (cagrilintide/semaglutide)	Injectable	Novo Nordisk	Dual agent. A long-acting amylin (pancreatic hormone) analogue and a GLP-1R agonist	4Q 2026	1Q 2027	1Q 2029		
CT-388	Injectable	Genentech	Dual GLP-1 and GIP receptor agonist	2029 or later	2029 or later			
elecoglipron	Oral	Astra Zeneca	GLP-1 receptor agonist	2029 or later	2029 or later			
eloralintide/tirzepatide	Injectable	Eli Lilly	Amylin agonist with GLP/GIP inhibitor	2029 or later				
GSBR-1290	Oral	Structure Therapeutics	Nonpeptide GLP-1 receptor agonist	2029 or later	2029 or later			
IcoSema (insulin icodec/semaglutide)	Injectable	Novo Nordisk	Basal insulin/GLP-1R agonist		1Q 2027			
MariTide [maridebart/ cafraglutide]	Injectable	Amgen	Dual-acting, gastric inhibitory polypeptide (GIP) receptor antagonist and GLP-1R agonist	3Q 2028	2029 or later	4Q 2029	2029 or later	Heart Failure: Q4 2029
NN9541	Injectable	Novo Nordisk	Dual GLP-1 and GIP receptor agonist		2029 or later		2029 or later	
orforglipron	Oral	Eli Lilly	Nonpeptide GLP-1 receptor agonist	Approved 4/1/2026	Q2 2027	Q2 2027	2Q 2028	Stress Urinary Incontinence: 3Q 2029 Hypertension in obesity: 1Q 2029 Osteoarthritis: 4Q 2029
pemvidutide	Injectable	Altimmune	Dual GLP-1R agonist and glucagon receptor agonist	2029 or later				Alcohol Use Disorder: 2029 or later MASH: 2029 or later
PF08653944	Injectable	Pfizer	GLP-1 receptor agonist	1Q 2029				
retatrutide	Injectable	Eli Lilly	Triple agonist. Binds and activates the GLP-1, GIP and glucagon receptors	4Q 2027	1Q 2028	1H 2030		Osteoarthritis of the knee: 4Q 2027 Chronic low back pain: Q1 2029
RG6641	Injectable	Roche	Dual GLP-1 and GIP receptor agonist					Type-1 Diabetes: 2029 or later
survodutide	Injectable	Boehringer Ingelheim/ Zealand Pharma	Dual acting, Glucagon/GLP-1 receptor agonist	2Q 2027		Q4 2027		MASH: 2029 or later
VK2735	Injectable	Viking Therapeutics	Dual GLP-1 and GIP receptor agonist	1Q 2029				

Source: Pipeline Services. Pipeline Database, accessed April 2026. OSA: Obstructive sleep apnea; MASH: Metabolic Dysfunction-Associated Steatohepatitis; T2D: Type-2 Diabetes; CVRR: reduction of cardiovascular risk; OA- Osteoarthritis of the knee. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.


CVS Health

Kaiser Permanente

KAISER PERMANENTE®

Prescribing with purpose

A SMART, SAFE, SUSTAINABLE GLP-1 STRATEGY

Are GLP-1s a sustainable solution? Let's weigh the evidence.

Annual cost
of a GLP-1 medication[1]

$16,000

of patients stop taking GLP-1s within 2 years[2]

of lost weight comes back within a year[3]

KAISER PERMANENTE

1. Mozaffarian, *JAMA*, February 29, 2024. 2. Cohen, *Forbes*, July 11, 2024. 3. Wilding et al., *Diabetes, Obesity & Metabolism*, May 9, 2022.

GLP-1s for the right patients, for the right reasons

We don't prescribe GLP-1s in a vacuum

Personalized — based on each patient's health goals and medical history

Evidence-based — aligned with the latest clinical safety and efficacy guidelines

Integrated — connected care teams monitor side effects, track progress, and adjust treatment to support long-term health

Progressive — As GLP-1s are approved for new indications, we act quickly to develop safe and effective prescribing guidelines

of our GLP-1 prescriptions are for members with diabetes

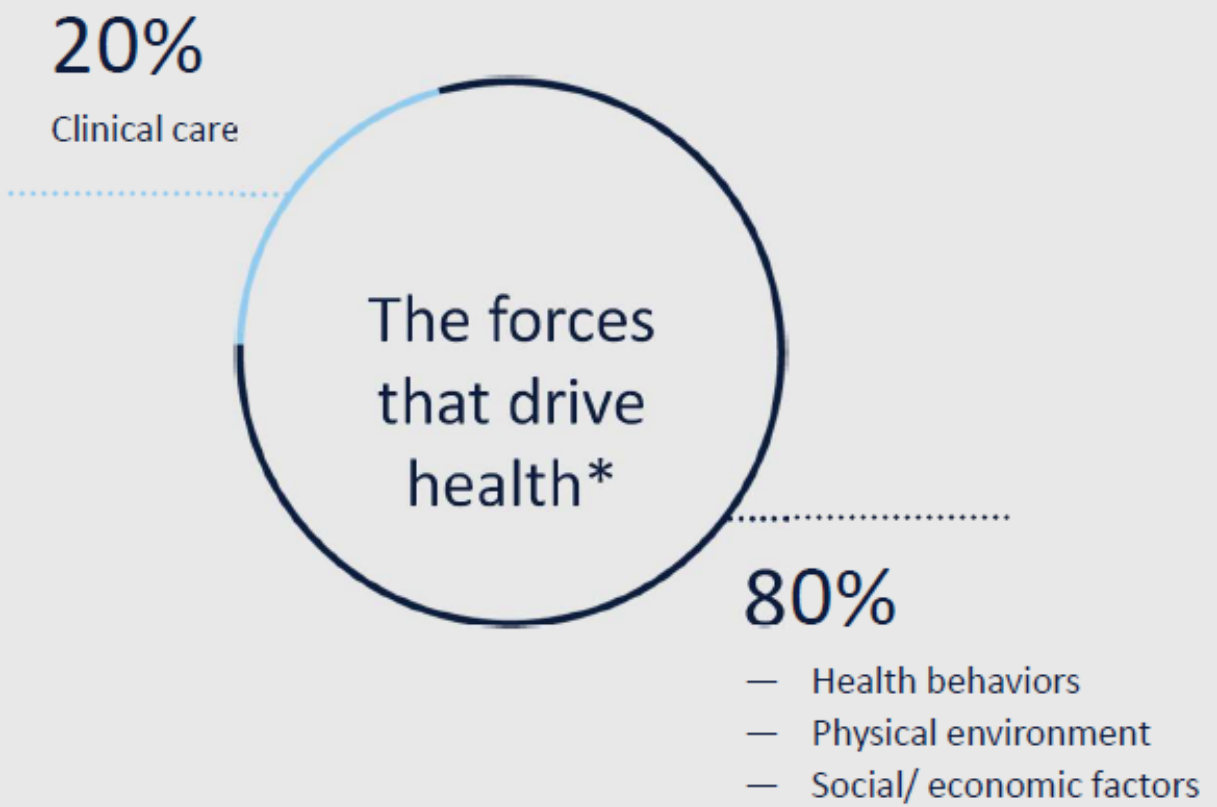
KAISER PERMANENTE®

GLP-1s work best when they don't work alone

GLP-1s are one tool. Not the only tool.

Kaiser Permanente's holistic approach:

- **Physical health:** Healthy diet, exercise, GLP-1s when clinically appropriate
- **Mental and social health:** Motivation for change, social drivers of health, and mental health support



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*Abrams et al., The Commonwealth Fund, December 15, 2023.

Safe and cost-effective prescribing strategies

Kaiser Permanente clinicians take an algorithmic approach to weight loss treatment plans—including beginning with safe, effective generic drugs. Clinical guidelines created in partnership between our integrated pharmacy system and clinicians are implemented alongside changes to the formulary.

Semaglutide Clinical Guidance

- Cost-effective, formulary development for drug selection in drug class
- Limited to a 30-day supply to minimize wastage of injectables
- Active monitoring of side-effects, patient tolerance, and adherence
- Measure weight loss by 16-weeks to confirm effectiveness
- Transition to safe and effective de-prescribing strategy

Supported by an integrated system and pharmacy

- Higher medication adherence
- Regular labs, check ins, and measurements
- Digital resources and tools
- Simple single eco-system

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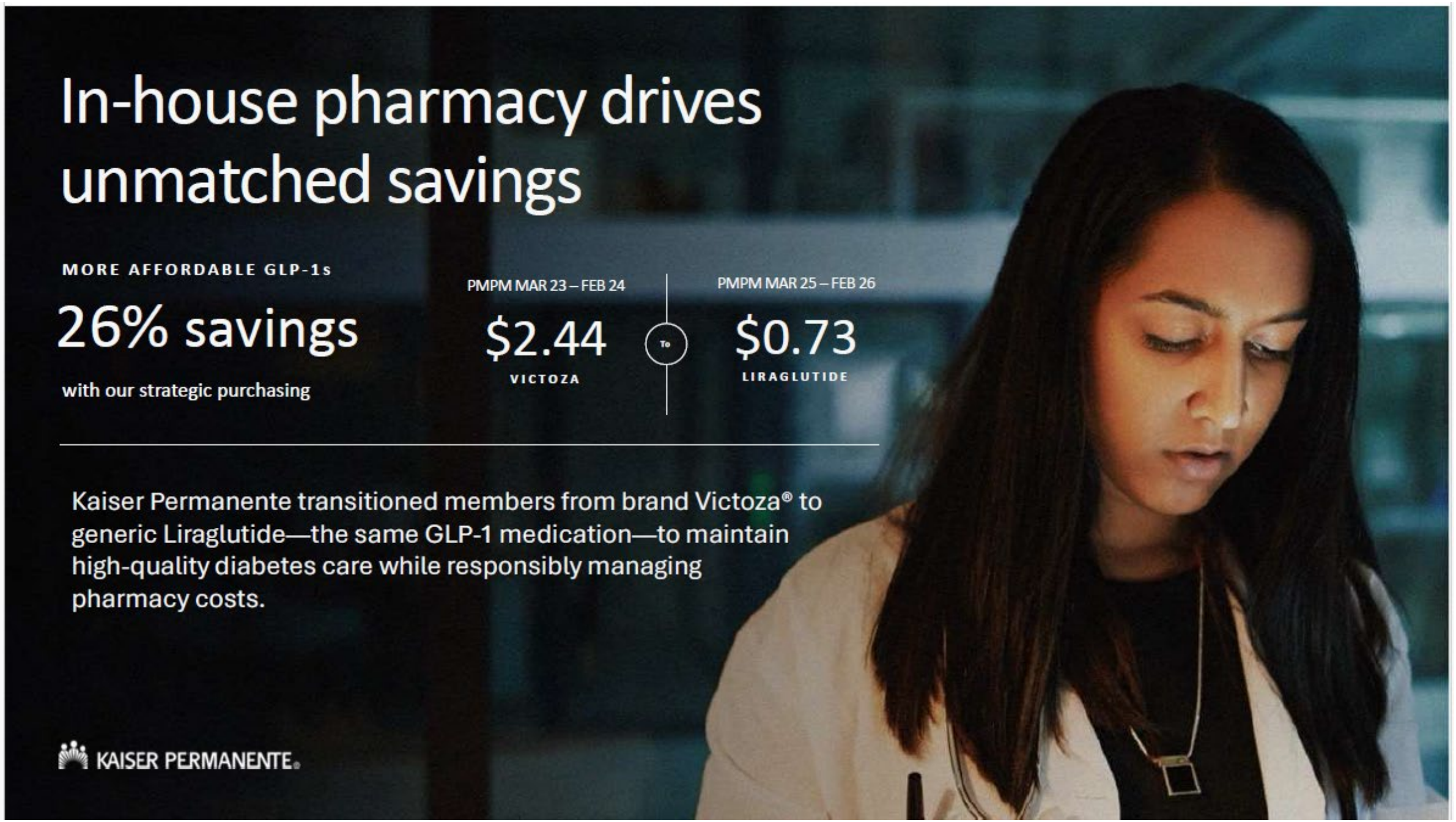
In-house pharmacy drives unmatched savings
MORE AFFORDABLE GLP-1s
26% savings
with our strategic purchasing
PMPM MAR 23 – FEB 24
$2.44
VICTOZA
To
PMPM MAR 25 – FEB 26
$0.73
LIRAGLUTIDE
Kaiser Permanente transitioned members from brand Victoza® to generic Liraglutide—the same GLP-1 medication—to maintain high-quality diabetes care while responsibly managing pharmacy costs.
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LACERA's GLP-1 Utilization

GLP-1 medications are mainly used to treat 3 conditions: diabetes, obesity with another condition, and Class III obesity.

AS OF FEBRUARY 2026

Early Retirees

	DIABETES	OBESITY WITH ANOTHER CONDITION	CLASS III OBESITY (BMI ≥40)	ALL OTHER MEMBERS	TOTAL MEMBERS
Members with condition	2,028	2,287	91	7,783	12,189
Treated members	271	107	12	13	403
% of members with condition being treated	13.36%	4.68%	13.19%	0.17%	3.31%

Medicare Retirees

	DIABETES	OBESITY WITH ANOTHER CONDITION	CLASS III OBESITY (BMI ≥40)	ALL OTHER MEMBERS	TOTAL MEMBERS
Members with condition	4,717	6,114	12	15,966	26,809
Treated members	464	221	1	53	739
% of members with condition being treated	9.84%	3.61%	8.33%	0.33%	2.76%

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Note: All metrics contain data for the current month only. Utilization and metrics are calculated on the ≥18 population.

Anthem

California Health Insurance Regulators

- California Department of Insurance (CDI)
  - Established in 1868
- Types of insurances regulated:
  - Auto
  - Health
  - Homeowners
  - Life
- Department of Managed Health Care (DMHC)
  - Established in 2000
- Focuses specifically on managed care oversight and consumer assistance

While there is consistency of GLP-1 coverage for type 2 diabetes and other approved medical indications (e.g., CV risk, MASH, and OSA), the DMHC generally imposes narrower medical-necessity standards than the DOI for weight-loss medications.

Department of Managed Health Care (DMHC)

Plans

Prudent Buyer

In State Plan II

In State Plan III

Membership Count

21,700 members

GLP-1 Clinical Requirements

Weight Management Indication: BMI ≥ 40

All Other Indications- Aligns with FDA Criteria

California Department of Insurance (CDI)

Plans

In-State and Out of State Plan I

Out-of-State Plan II and Out-of-State Plan III

Membership Count

12,500 members

GLP-1 Clinical Requirements

All Indications- Aligns with FDA Criteria

Operational Update

- LACERA is working with Anthem and CVS to update their systems to auto-adjudicate GLP-1 claims solely for weight loss on or before July 1, 2026.
- Once system updates are complete, coverage decisions for GLP-1 weight-loss medications will be made automatically based on whether the member's plan is regulated by the DMHC or CDI.
- In the interim, members can use the appeal process through CVS to have eligible GLP-1 weight loss claims manually reprocessed.
  - During the most recent 12-month period, six (6) LACERA members have had their weight loss GLP-1 claim appeals reprocessed.

Biographies

Soo Rhee MD

Medical Director,
Medical Affairs

LOCATION
California

Professional Biography

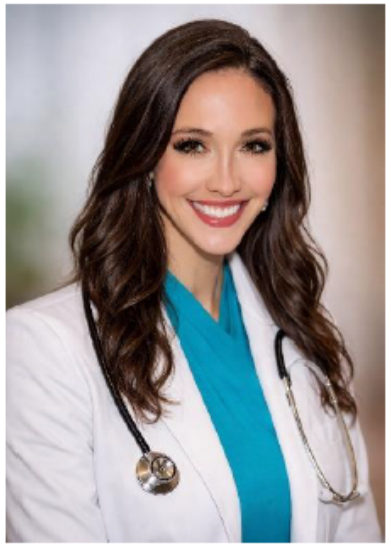
Dr. Soo S. Rhee, MD is a physician leader with expertise in direct patient care, utilization management, and data-driven healthcare innovation.

Dr. Rhee currently serves as a Medical Director, Medical Affairs at CVS Caremark. She provides clinical expertise across utilization management, research initiatives, and clinical program development. She partners with cross-functional teams to ensure evidence-based decision-making, scalable clinical solutions, and high-quality patient outcomes.

Dr. Rhee has also served as a clinical subject matter expert in roles outside of CVS Caremark, working with product development, program development, marketing, and client services, to design and implement an anti-obesity medication (AOM) point solution for health plans. Dr. Rhee is board certified in Endocrinology, Diabetes, and Metabolism; Internal Medicine; and Obesity Medicine.

PERMANENTE MEDICINE®
Southern California
Permanente Medical Group

Biography *Kimberly Petrick, MD*



Permanente Physician Lead for National Accounts, Southern California Permanente Medical Group (SCPMG)

Regional Physician Ambassador, Walnut Center, Pasadena

Family Medicine and Urgent Care Physician, Woodland Hills Medical Center

Dr. Kimberly Petrick joined Kaiser Permanente in 2015 and is a Family Medicine Physician practicing at Kaiser Permanente's Woodland Hills Medical Center Urgent Care. She also serves as a Southern California Kaiser Permanente Regional Physician Ambassador and as the Permanente Physician Lead (PPL) for National Accounts for the Southern California Permanente Medical Group (SCPMG).

In her clinical and leadership roles, she partners closely with Kaiser Permanente's Sales, Account Management, and Public Affairs teams to promote healthy, thriving workforces and advance community wellness through media and public engagement. She continues to practice frontline medicine in primary and urgent care with a strong emphasis on patient partnership, whole-person care, and balanced physical and emotional wellness.

Dr. Petrick is board certified by the American Board of Family Medicine and is bilingual in Spanish.

Joseph A Karam MD MBA FACS

Medical Director Grievances & Appeals

Joseph.Karam@anthem.com
818.438.7351

Joe is a lead medical director for Anthem's Grievances and Appeals department and is based out of our Woodland Hills office.

Joe is responsible for managing the daily operations of the medical appeals team and is also responsible for interfacing with the California regulators for medical issues. He also manages the Quality of Care review process within Anthem.

Joe is boarded in Surgery, Trauma, and Critical Care Medicine. He still practices part time at a local trauma center.

He received his medical degree from Jefferson College of Medicine and MBA from Fox School of Business at Temple University.

In his spare time he enjoys world travel and photography.

Stephen E. Murphy, CEBS

Senior Vice President and Benefits Consultant, Los Angeles

Expertise

Steve is a Senior Vice President and Benefits Consultant in Segal's Los Angeles office with more than 35 years of health benefits experience. He works with state, city and county governments as well as other public sector clients to develop and maintain their employee benefit plans. Steve has specialized expertise in health strategy development and implementation, claim reporting and data analysis, and vendor evaluation, selection and management.

Education background

Steve holds a BS in Business Administration from the University of Southern California and a MS in Human Resource Management from Boston University. He is a Certified Employee Benefits Specialist and holds a certificate in Global Business Management from the International Foundation of Employee Benefit Plans.