# IN PERSON & VIRTUAL BOARD MEETING

*The Committee meeting will be held prior to the Board of Retirement meeting scheduled prior.

## TO VIEW VIA WEB

## 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 REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE

COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:30 A.M., WEDNESDAY, JULY 1, 2026

*This meeting will be conducted by the Insurance, Benefits and Legislative Committee and Board of Retirement both in person and by teleconference under California Government Code Sections 54953.8.3.*

*Any person may view the meeting in person at LACERA's offices or online at [https://LACERA.gov/leadership/board-meetings.](https://LACERA.gov/leadership/board-meetings)*

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


COMMITTEE TRUSTEES:

Les Robbins, Chair
Aleen Langton, Vice Chair
Shawn R. Kehoe, Trustee
Ernesto J. Pantoja, Trustee
Jason E. Green, Alternate Trustee


I. CALL TO ORDER

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB 707 Teleconference Locations

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of June 3, 2026

IV. PUBLIC COMMENT

(Members of the public may address the Committee 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 Committee. 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. If you have any questions, you may email PublicComment@lacera.gov.)

V. REPORTS

A. **Semi-Annual Report on Approved Engagements**
Barry W. Lew, Legislative Affairs Officer
(For Information Only) (Memo dated June 18, 2026)

B. **Engagement Report for June 2026**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

C. **LACERA GLP-1 Update**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only) (Memo dated June 12, 2026)

D. **Staff Activities Report for June 2026**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

E. **LACERA Claims Experience**
Stephen Murphy, Segal Consulting
(Presentation)

V. REPORTS (Continued)

F. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Information Only)

VI. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

VII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

VIII GOOD OF THE ORDER
(For Information Purposes Only)

IX. ADJOURNMENT

**The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

**Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee 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 Committee, at LACERA's offices at 300 North Lake Avenue, Suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday *and will also be posted on lacera.com at the same time, Board Meetings | LACERA*.**

***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, 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.***

MINUTES OF THE REGULAR MEETING OF THE INSURANCE, BENEFITS &

LEGISLATIVE COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:02 A.M. – 8:38 A.M., WEDNESDAY, JUNE 3, 2026

This meeting was conducted by the Insurance, Benefits & Legislative Committee both in person and by teleconference under California Government Code Section 54953.8.3.

COMMITTEE TRUSTEES

PRESENT: Les Robbins, Chair

Aleen Langton, Vice Chair *(arrived at 8:08 a.m.)*

Shawn R. Kehoe, Trustee *(arrived at 8:08 a.m.)*

Jason E. Green, Alternate Trustee *(arrived at 8:08 a.m.)*

ABSENT; Ernesto J. Pantoja, Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

JP Harris, Trustee

Wayne Moore, Trustee

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Luis A. Lugo, Chief Executive Officer

JJ Popowich, Assistant Executive Officer

Jessica Baxter, Assistant Executive Officer

Steven P. Rice, Chief Counsel

Barry W. Lew, Legislative Affairs Officer

Segal Consulting
Stephen Murphy, Sr. Vice President
Amber Turner, Vice President, Audits
Felicia Zhang, Sr. Health Benefits Data Consultant

I. CALL TO ORDER

This meeting was called to order by Chair Robbins at 8:02 a.m.

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB 707 Teleconference Locations

There were no requests received.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of May 6, 2026

Trustee Kehoe made a motion, Trustee Robbins seconded, to approve the minutes of the regular meeting of May 6, 2026. The motion passed by the following roll call vote:

Yes: Langton, Kehoe, Green, Robbins

No: None

Absent: Pantoja

*(This item was handled out of order after Item V-E.)*

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. REPORTS

A. **Engagement Report for May 2026**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

The engagement report was discussed. This item was received and filed.

B. **Staff Activities Report for May 2026**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

The staff activities report was discussed. This item was received and filed.

V. REPORTS (Continued)

C. **Anthem Blue Cross and Cigna Dental July 2024-June 2025 Annual Audit Findings**
Cassandra Smith, Director, Retiree Healthcare
Amber Turner, Segal Consulting
Felicia Zhang, Segal Consulting
(Presentation) (Memo dated May 14, 2026)

Ms. Turner and Ms. Zhang presented the results of the annual Cigna Dental Plan and Anthem Blue Cross Medical Plan audits and answered questions from the Committee. This item was received and filed.

D. **LACERA Claims Experience**
Stephen Murphy, Segal Consulting
(Presentation)

The LACERA Claims Experience reports through April 2026 were discussed. This item was received and filed.

E. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Information Only)

Segal Consulting gave an update on federal legislation. This item was received and filed.

VI. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

There was nothing to report.

VII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

There was nothing to report.

VIII. GOOD OF THE ORDER
(For Information Purposes Only)

There was nothing to report.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 8:38 a.m.

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

**FOR INFORMATION ONLY**

June 18, 2026

TO: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Aleen Langton, Vice Chair
Ernesto J. Pantoja
Shawn R. Kehoe
Jason Green, Alternate

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: July 1, 2026 Insurance, Benefits and Legislative Committee Meeting

SUBJECT: **Semi-Annual Report on Approved Engagements**

## LEGAL AUTHORITY

The Board of Retirement's (BOR) Policy on Engagement for Public Policy Issues Relating to Plan Administration and Retirement and Health Care Benefits provides that staff will present semi-annual reports to the Insurance, Benefits and Legislative Committee (IBLC) each year as to the status of all approved engagements

## ENGAGEMENTS

*Meetings with Congress*

The National Conference of Public Employee Retirement Systems (NCPERS) 2026 Legislative Conference was postponed this year due to weather and rescheduled for November 2026. Legislative Affairs Officer Barry Lew instead attended the National Association of State Retirement Administrators (NASRA) Winter System Roundtable and Joint Legislative Conference and attended meetings with Congressional members and their staff arranged by LACERA's legislative advocate Anthony J. Roda.

The meetings were with House members and their staff of the Los Angeles County Delegation including Ted Lieu, Nanette Barragan, Jimmy Gomez, Laura Friedman, and Sydney Kamlager.

Topics of discussion included the effects on public sector retirement systems if the Unrelated Business Income Tax (UBIT) or mandatory Social Security coverage were to be enacted.

*Meetings with California State Legislature*

On May 5, 2026, Chief Executive Officer Luis Lugo and Legislative Affairs Officer Barry

W. Lew met with members of the Los Angeles County Delegation of the Assembly and Senate in meetings arranged by legislative advocate Naomi Padron. The Assembly members included Pilar Schiavo, Blanca Rubio, Mike Fong, Tina McKinnor, Blanca Pacheco, and Michelle Rodriguez. The Senate member Caroline Menjivar. Staff also had meetings with CalPERS CEO Marcie Frost and Sacramento County Employees' Retirement System CEO Eric Stern.

Staff provided an introduction to Mr. Lugo as LACERA's new CEO and an overview of LACERA's history and operations and highlighted key findings of the economic impact study that was conducted in 2022, in particular that over 80% of LACERA retirees remain in California and generate $3 billion in statewide annual economic activity. We also informed the legislators that we were in the process of updating the study for 2026 and creating fact sheets about the economic impact of LACERA retirees in their own districts.

*Legislative Positions*
During the 2026 legislative session, LACERA adopted positions on the following bills.

AB 1619 (Valencia): Would authorize retirement boards of systems operating under the County Employees Retirement Law of 1937 to increase the compensation rate for appointed and retired trustees to not more than $320 per meeting, if the authority is made operative by a board of supervisors.

> Status: From committee: Do pass and re-refer to Committee on Appropriations. (06/17/2026)
>
> BOR Position: Support if Amended.

AB 2780 (PE&R Committee): Would make technical changes to the various provisions of the County Employees Retirement Law of 1937 for more efficient and effective plan administration.

> Status: From committee: Do pass and re-refer to Committee on Appropriations with recommendation: To consent calendar. (06/17/2026)
>
> Board Position: Support.

*SACRS Legislative Committee*
The State Association of County Retirement Systems (SACRS) Legislative Committee continues to meet virtually, and staff participates in monthly virtual meetings and annual in-person meetings of the Committee. The Committee's activities include monitoring current legislation, formulating and advocating legislative proposals, and discussing current events related to public pension plans. The Committee is preparing its legislative platform for sponsorship by the SACRS systems for the 2027 legislative session.

**CONCLUSION**
Staff will continue to work with its legislative advocates and the SACRS Legislative Committee to monitor and advocate on issues relevant to LACERA.

**Reviewed and Approved:**

**Luis Lugo, Chief Executive Officer**

cc: Board of Investments
Luis Lugo
JJ Popowich
Jessica Baxter
Steven P. Rice
Cynthia Martinez
Anthony J. Roda, Williams & Jensen
Naomi Padron, MKP Government Relations

**INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE**
**ENGAGEMENT REPORT**
**JUNE 2026**
**FOR INFORMATION ONLY**

**Social Security Trust Fund Depletion in 2032**

The Social Security Administration's 2026 trustees report projects that the Old-Age and Survivors Insurance (OASI) trust fund, which pays retirement benefits, will be depleted in late 2032—slightly earlier than previously estimated. Social Security is primarily funded through payroll taxes, with trust fund reserves covering gaps when benefit payments exceed tax revenue.

The report shows that—

- The Old-Age and Survivors (OASI) Trust Fund will be able to pay 100 percent of benefits until the fourth quarter of 2032. At that point, the fund's reserves are depleted, and continuing program income will be able to pay 78 percent of benefits.
- The Disability Insurance (DI) Trust Fund is projected to pay 100 percent of benefits through to 2100.
- If the OASI and DI Trust Funds projections were combined, the resulting fund would be able to pay 100 percent of benefits until the third quarter of 2034. (There is currently no legal authority that permits combining the trust funds.)
- The Hospital Insurance (HI) Trust Fund will be able to pay 100 percent of benefits until the second quarter of 2033. At that point, the fund will be able to pay 89 percent of benefits. The HI Trust Fund pays for Medicare Part A (Hospital Insurance).
- The Supplementary Medical Insurance (SMI) Trust Fund is adequately financed into the indefinite future because its main financing sources of premiums and federal contributions are automatically adjusted each year to cover costs for the upcoming year. The SMI Trust Fund pays for Part B (Doctor/Outpatient Services) and Part D (Prescription Drug Coverage).

Although Social Security has never missed a payment, the report underscores a growing financing gap and the likelihood of benefit reductions unless Congress enacts reforms to strengthen long-term solvency. (Source) (Source)

**Bipartisan Social Security Commission Act**

A bipartisan bill introduced by Reps. Tom Cole (R-OK) and Tom Suozzi (D-NY) would create a formal process to address Social Security's long-term solvency but does not directly change benefits. The proposal responds to projections that the retirement trust

fund will be depleted by 2032, after which only about 78% of benefits would be payable, triggering automatic cuts without congressional action.

The legislation would establish a 13-member bipartisan commission to develop reform recommendations within one year. Members would be appointed by congressional leaders, key tax committee officials, and the president, with at least two outside experts included. Any proposal would require supermajority approval (nine members) and would receive expedited, up-or-down consideration in Congress without amendment—aimed at forcing legislative action.

Supporters argue the bill mirrors the 1983 commission that helped extend Social Security's solvency and creates accountability to avoid inaction. The commission would examine options such as tax increases, benefit adjustments, or eligibility changes.

The bill is in early stages and would need to pass committee and both chambers. Even if enacted, reforms would likely follow later, after the commission issues recommendations. (Source) (Source)

**No State Spared: Mapping the Impact of Social Security's Insolvency**
The Committee for a Responsible Federal Budget, a nonpartisan nonprofit organization that focuses on federal fiscal policy, released a report on the effects of the depletion of the Social Security Trust Fund in 2032.

Using a projected 24% benefit cut and the most recent state-level data available, the report estimates that—

- Average monthly cuts would surpass $500 in 29 states, with the largest cuts in Connecticut, Delaware, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, Utah, and Washington.
- More than 15% of the population would be directly impacted in 47 states, with the largest share of the population in Delaware, Maine, Michigan, Montana, New Hampshire, Pennsylvania, South Carolina, Vermont, West Virginia, and Wisconsin.
- Total benefit cuts would exceed 1% of Gross Domestic Product (GDP) in 40 states, with the largest economic impacts in Alabama, Arkansas, Idaho, Maine, Michigan, Mississippi, Montana, South Carolina, Vermont, and West Virginia.

The following are effects in California—

- Population impact: 15% or 5,975,956 beneficiaries affected (ranked first among states).
- Average monthly cut: $490.

- Statewide impact: 0.8% as a share of the state economy with $33.4 billion benefits lost (ranked first among states).

(Source) (Source)

**Society of Actuaries Biennial Retirement Risk Survey**

The Society of Actuaries released a report of its biennial risk survey, which was conducted in 2024. The report addresses Americans' retirement concerns and preparedness, income and spending patterns in retirement, retirement planning, the impact of shocks and unexpected events, and inflation. The report was based on a survey of 2,012 individuals split between 1,007 pre-retirees and 1,005 retirees.

The following are some key findings in the report—

- Many retirees exit the workforce earlier than expected. Lower income respondents are often driven by health status, whereas higher income respondents by personal and financial factors such as job satisfaction, family obligations, and achieving savings goals earlier.
- Respondents' financial situation in retirement generally matches their expectations, though there are variations by income levels and demographic backgrounds.
- Regarding overall sense of preparedness, pre-retirees reported increased financial strain and greater concern about broader economic and disruptive events, whereas retirees seemed better able to adjust spending when finances tightened.
- Although caregiving responsibilities are currently minimal with respondents, it can materially influence retirement planning. Although over one-quarter of respondents expect they themselves may need caregiving, nearly half have not planned for it.
- Family support can materially affect retirement readiness. Pre-retirees provide financial support for adult children and parents/in-laws, which reduces their ability to save. Pre-retirees also feel less prepared than retirees for family-related retirement costs such as funeral, home repairs, and medical emergencies.
- Inflation impacts weigh more heavily on pre-retirees, who report higher concern and impact. Lower income respondents are more likely to make immediate spending changes, whereas higher income respondents take longer-term actions, such as adjusting investment strategies.
- Technology use is widespread with smartphones being nearly universal in daily use. Younger and higher income pre-retirees report much higher AI use than retirees. Online banking is the most-used financial platform and is perceived as lower risk than other tools. (Source)

LACERA

June 12, 2026

TO: Insurance, Benefits & Legislative Committee
Les Robbins, Chair
Aleen Langton, Vice Chair
Ernesto Pantoja
Shawn Kehoe
Jason Green, Alternate

FROM: Cassandra Smith, Director
Retiree Healthcare Division

FOR: July 1, 2026, Insurance, Benefits & Legislative Committee

SUBJECT: **LACERA GLP-1 UPDATE**

At the May 19, 2026, Board of Retirement Offsite, the Board received a panel presentation on GLP-1 weight-loss drugs from representatives of Anthem, CVS Caremark, and Kaiser Permanente.

The discussion was prompted by the FDA's expanded approval of these drugs for obstructive sleep apnea, metabolic dysfunction-associated steatohepatitis (MASH), and cardiovascular risk reduction. As these indications expanded, the Retiree Healthcare Division began receiving more escalated member requests for coverage, which had previously been limited to members with a Type 2 diabetes diagnosis only. Retirees and eligible dependents diagnosed with these conditions must still meet the medical-necessity criteria of their specific plan. Additional information on which LACERA medical plans are regulated by the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI) is provided in the attached Segal memo.

The FDA first approved a GLP-1 drug for Type 2 diabetes in 2005. Since then, approved uses have expanded to include obstructive sleep apnea, MASH, and cardiovascular risk reduction.

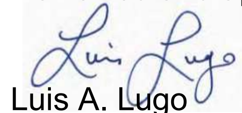
Staff, in consultation with Segal, began discussions with Anthem and CVS and learned that the DMHC and DOI apply different medical-necessity standards. The attached Segal memo also outlines the regulatory framework for LACERA's medical plan offerings.

Before these recent developments, GLP-1 drugs were not covered under the LACERA group plan unless the member had a Type 2 diabetes diagnosis. In the interim, members diagnosed under the expanded indications have been advised to file appeals, so eligible claims can be manually reprocessed. Over the most recent 12-month period, six LACERA members had weight-loss GLP-1 claims reprocessed.

Anthem and CVS are updating their systems to auto-adjudicate GLP-1 claims solely for weight loss on or before July 1, 2026. When system updates are complete, coverage decisions for GLP-1 weight loss medications will be made automatically based on whether the member plan is regulated by the DMHC or DOI.

Staff appreciate Segal's continued collaboration and guidance in supporting LACERA's retiree healthcare cost management and program administration.

Reviewed and approved:



Luis A. Lugo
Deputy Chief Executive Officer

Attachment

Segal

Stephen Murphy
Senior Vice President Benefits Consultant
T 8189566726
smurphy@segalco.com

500 North Brand Boulevard
Suite 1400
Glendale, CA 91203-3338
segalco.com

June 15, 2026

Cassandra Smith
Director, Retiree Healthcare
LACERA
300 N. Lake Avenue, Suite 300
Pasadena, CA 91101

**Re: GLP-1 Coverage**

Dear Cassandra:

# Overview

National demand for weight-loss medications—particularly GLP-1 agents such as Wegovy, Ozempic, Mounjaro, and Zepbound—has surged dramatically and continues to accelerate in 2026. Analysts project that the U.S. GLP-1 patient population will climb from roughly 10 million in 2025 to 25 million by 2030, driven by broader clinical indications, declining prices, and the introduction of more convenient oral formulations.

This document summarizes current GLP-1 coverage rules for weight-loss indications across California regulators, outlines how these rules apply to LACERA plans, and provides an update on expected claims adjudication improvements. It also highlights upcoming federal changes under the CMS' temporary Bridge program, which will broaden GLP-1 access under Medicare Part D during the period 7/1/2026 – 12/31/2027.

## Background on GLP-1s

In 2005, the FDA-approved the first glucagon-like peptide-1 (GLP-1) for the treatment of type 2 diabetes. Familiar brands include Victoza, Trulicity, Ozempic, and Rybelsus. Over time, FDA-approved GLP-1 indications expanded beyond type 2 diabetes to include cardiovascular risk reduction, obstructive sleep apnea, and metabolic dysfunction–associated steatohepatitis (MASH).

## Regulatory Framework

Commercial health plans in California are regulated by either the Department of Managed Health Care (DMHC) or Department of Insurance (DOI). 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.

### Table 1: Weight-Loss GLP-1 Coverage Standards

| Regulator | Coverage Criteria |
|---|---|
| DMHC | Class III “Severe” Obesity (BMI ≥ 40) |
| DOI | Follow FDA labeling (BMI ≥ 30 above or BMI ≥ 27 with comorbidity) |

## LACERA Plan Implications

LACERA’s Anthem health plans are regulated by either the DMHC or DOI. This determines which BMI criteria apply for GLP-1 weight-loss coverage.

### Table 2: LACERA Anthem Plan Regulatory Alignment

| Regulator | Coverage Criteria |
|---|---|
| DMHC | Prudent Buyer (CA), Plan II (CA), Plan III (CA) |
| DOI | Plan I (All), Plan II (non-CA), Plan III (non-CA) |

LACERA’s other commercial plans (i.e., Cigna, Kaiser Permanente, and UnitedHealthcare) are also regulated by the DMHC and provide coverage of GLP-1s solely for weight loss to individuals diagnosed with Class III obesity (i.e., BMI ≥ 40).

# 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 DOI.

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 reprocessed.

# Medicare and Medicaid

The Centers for Medicare & Medicaid Services (CMS) has introduced the Better Approaches to Lifestyles and Nutrition for Comprehensive health (BALANCE) Model, a voluntary, alternative payment model, designed to expand access to GLP-1 medications. The BALANCE Model:

- Authorizes GLP-1 coverage for weight loss for the first time, subject to BALANCE Model demonstration constraints.
- Creates standardized coverage and pricing rules.
- Launches Medicaid participation as early as May 2026.
- Originally expected to launch for Medicare Part D participation in January 2027, but implementation has been delayed pending further negotiations.

This initiative represents a significant shift in federal policy regarding GLP-1 access and is expected to accelerate patient demand, which may increase plan costs for LACERA and other plan sponsors. Participation in the BALANCE Model is proposed to occur at the plan level and would require election by the Part D sponsor to opt into the program.

While CMS continues to evaluate the BALANCE model as a potential pathway for expanding GLP-1 coverage under Medicare Part D, CMS has implemented a new temporary demonstration program known as Medicare GLP-1 Bridge. This short-term demonstration will operate from July 1, 2026, through December 31, 2027, and operates outside of the Medicare Part D benefit. As a result, Part D sponsors are not required to opt into the demonstration for eligible beneficiaries to obtain coverage, nor will they bear any financial risk associated with claims incurred during the demonstration period.

However, CMS has issued guidance to Part D plan sponsors clarifying eligibility, prior authorization, and marketing requirements for the Medicare GLP-1 Bridge. Under this guidance, the Bridge demonstration is limited to beneficiaries who do not otherwise have access to GLP-1 drugs for weight loss only under the Medicare Part D benefit. Beneficiaries who qualify for GLP-1 coverage for indications currently covered under Part D, such as type 2 diabetes or cardiovascular risk reduction, are not eligible for the Bridge, regardless of formulary status or cost-sharing differences.

Part D plan sponsors must continue to provide coverage for GLP-1 drugs for all covered indications in accordance with their approved formularies and utilization management programs. CMS explicitly prohibits sponsors from denying or limiting access to Part D–covered GLP-1 drugs, or otherwise structuring benefits or communications in a manner that encourages beneficiaries to obtain coverage through the Bridge instead of the Part D benefit.

Sincerely,

Stephen Murphy
Senior Vice President Benefits Consultant

cc: Michael Szeto, Segal
Wesley Clare, Segal
Jessica Kuhlman, Segal
Richard Ward, Segal

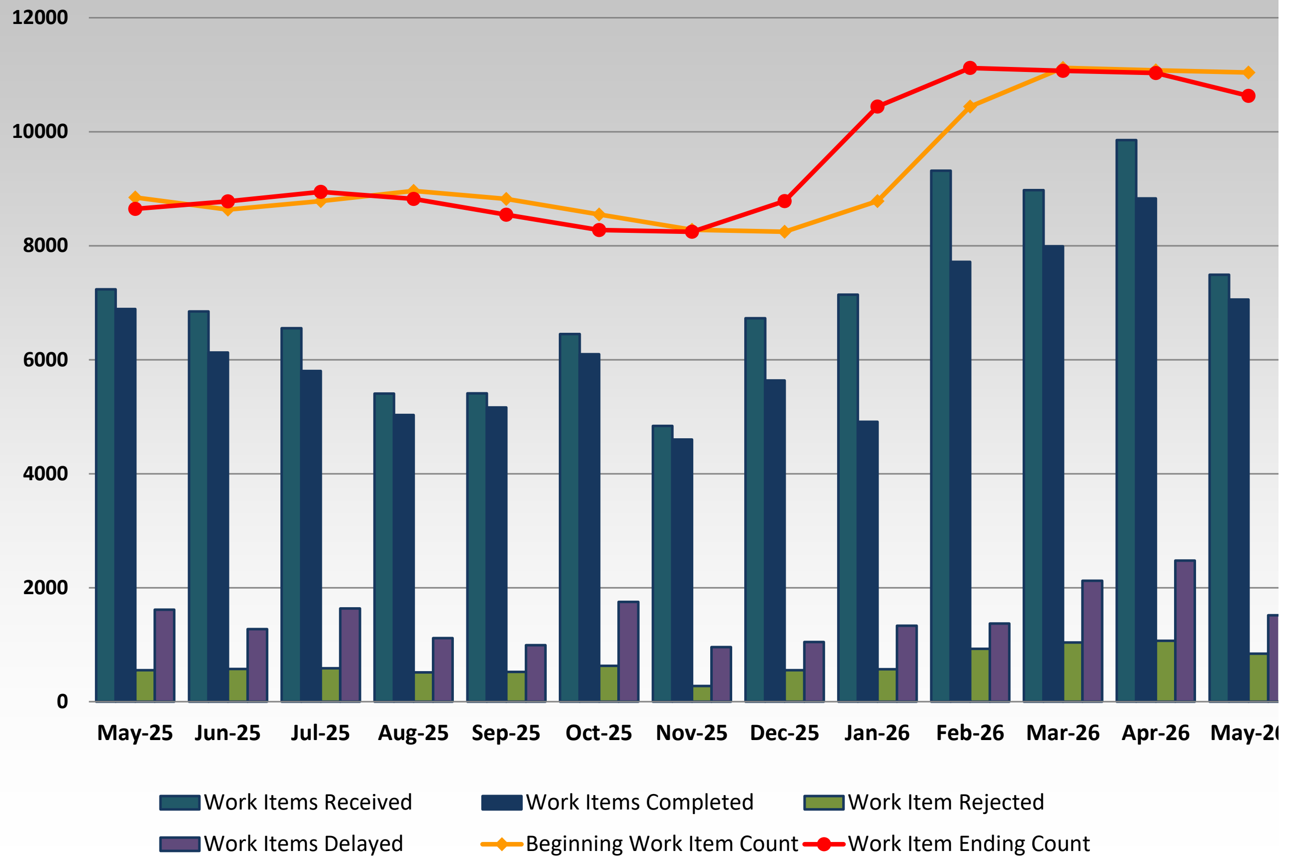
**INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE**
**RETIREE HEALTHCARE BENEFITS PROGRAM**
**STAFF ACTIVITIES REPORT**
**June 2026**
**FOR INFORMATION ONLY**

## SAVE THE DATE: LACERA Retiree Healthcare Wellness Program - Staying Healthy Together – Fall Workshop

LACERA's Retiree Healthcare Fall Retiree Staying Healthy half-day retiree wellness workshop planning has kicked off and in process.

The Fall workshop will be held on September 29, 2026, at the Diamond Bar Center in Diamond Bar, CA.

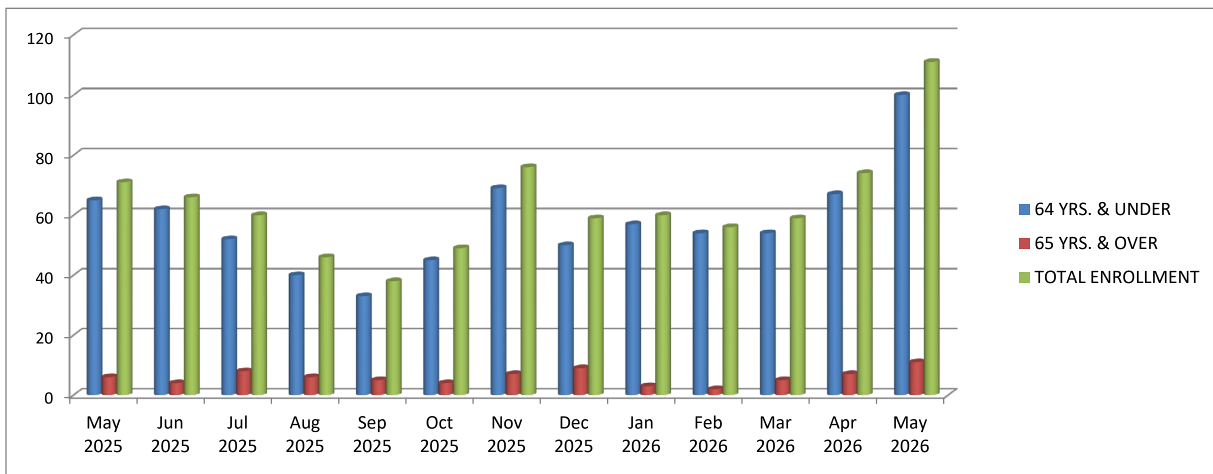
More details about the agenda and logistics will be shared soon. In the meantime, save the date as we hope that you can join us this fall at the Diamond Bar Center in Diamond Bar.




| | Beginning Work Item Count | Work Items Received | Work Items Completed | Work Item Rejected | Work Items Delayed | Work Item Ending Count |
|---|---|---|---|---|---|---|
| **May-25** | 8849 | 7237 | 6888 | 553 | 1612 | 8645 |
| **Jun-25** | 8633 | 6847 | 6128 | 574 | 1272 | 8778 |
| **Jul-25** | 8783 | 6552 | 5803 | 586 | 1635 | 8946 |
| **Aug-25** | 8960 | 5405 | 5030 | 515 | 1116 | 8820 |
| **Sep-25** | 8821 | 5408 | 5161 | 524 | 992 | 8544 |
| **Oct-25** | 8550 | 6452 | 6098 | 630 | 1751 | 8274 |
| **Nov-25** | 8278 | 4840 | 4600 | 274 | 959 | 8244 |
| **Dec-25** | 8245 | 6729 | 5637 | 552 | 1045 | 8785 |
| **Jan-26** | 8785 | 7142 | 4912 | 571 | 1332 | 10444 |
| **Feb-26** | 10444 | 9315 | 7715 | 926 | 1370 | 11118 |
| **Mar-26** | 11121 | 8975 | 7989 | 1039 | 2121 | 11068 |
| **Apr-26** | 11077 | 9854 | 8832 | 1070 | 2476 | 11029 |
| **May-26** | 11037 | 7491 | 7057 | 842 | 1515 | 10629 |

## Retirees Monthly Age Breakdown
## MAY 2025 - MAY 2026

| Disability Retirement | | | |
|---|---|---|---|
| MONTH | 64 YRS. & UNDER | 65 YRS. & OVER | TOTAL ENROLLMENT |
| May 2025 | 65 | 6 | 71 |
| Jun 2025 | 62 | 4 | 66 |
| Jul 2025 | 52 | 8 | 60 |
| Aug 2025 | 40 | 6 | 46 |
| Sep 2025 | 33 | 5 | 38 |
| Oct 2025 | 45 | 4 | 49 |
| Nov 2025 | 69 | 7 | 76 |
| Dec 2025 | 50 | 9 | 59 |
| Jan 2026 | 57 | 3 | 60 |
| Feb 2026 | 54 | 2 | 56 |
| Mar 2026 | 54 | 5 | 59 |
| Apr 2026 | 67 | 7 | 74 |
| May 2026 | 100 | 11 | 111 |

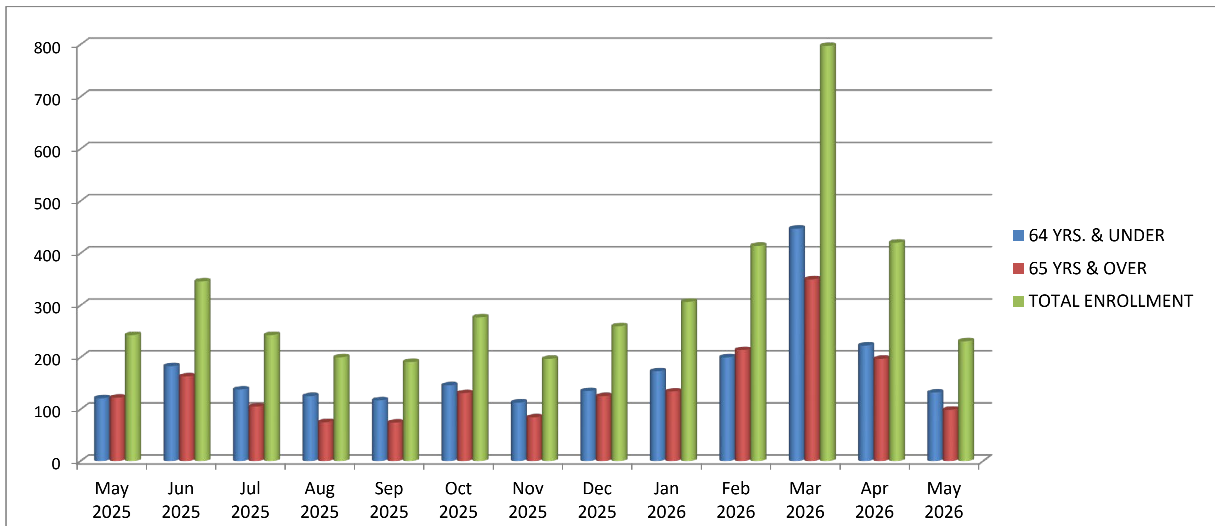



**PLEASE NOTE: Next Report will include the following dates: June 1, 2025, through June 30, 2026.**

## Retirees Monthly Age Breakdown
## MAY 2025 - MAY 2026

**Service Retirement**

| MONTH | 64 YRS. & UNDER | 65 YRS & OVER | TOTAL ENROLLMENT |
|---|---|---|---|
| **May 2025** | 121 | 122 | 243 |
| **Jun 2025** | 183 | 163 | 346 |
| **Jul 2025** | 138 | 105 | 243 |
| **Aug 2025** | 125 | 75 | 200 |
| **Sep 2025** | 117 | 74 | 191 |
| **Oct 2025** | 146 | 131 | 277 |
| **Nov 2025** | 113 | 84 | 197 |
| **Dec 2025** | 135 | 125 | 260 |
| **Jan 2026** | 173 | 134 | 307 |
| **Feb 2026** | 200 | 214 | 414 |
| **Mar 2026** | 447 | 350 | 797 |
| **Apr 2026** | 223 | 197 | 420 |
| **May 2026** | 132 | 99 | 231 |




**PLEASE NOTE: Next Report will include the following dates: June 1, 2025, through June 30, 2026.**

**Medicare Part B Reimbursement and Penalty Report**
**PAY PERIOD 6/30/2026**

| Deduction Code | No. of Members | Reimbursement Amount | No. of Penalties | Penalty Amount |
|---|---|---|---|---|
| **ANTHEM BC III** | | | | |
| 240 | 8042 | $1,500,732.60 | 0 | $0.00 |
| 241 | 133 | $24,051.00 | 0 | $0.00 |
| 242 | 1063 | $206,371.20 | 0 | $0.00 |
| 243 | 4933 | $1,888,424.96 | 0 | $0.00 |
| 244 | 14 | $2,437.40 | 0 | $0.00 |
| 245 | 67 | $12,642.00 | 0 | $0.00 |
| 246 | 12 | $2,255.70 | 0 | $0.00 |
| 247 | 193 | $38,857.30 | 0 | $0.00 |
| 248 | 13 | $4,250.20 | 0 | $0.00 |
| 249 | 96 | $42,460.50 | 0 | $0.00 |
| 250 | 16 | $5,957.00 | 0 | $0.00 |
| **Plan Total:** | **14,582** | **$3,728,439.86** | **0** | **$0.00** |
| | | | | |
| **KAISER SR. ADVANTAGE** | | | | |
| 394 | 24 | $4,432.60 | 0 | $0.00 |
| 397 | 2 | $347.50 | 0 | $0.00 |
| 398 | 14 | $5,681.20 | 0 | $0.00 |
| 403 | 12632 | $2,326,323.91 | 0 | $0.00 |
| 413 | 1646 | $322,581.10 | 0 | $0.00 |
| 418 | 6604 | $2,489,343.92 | 1 | $51.50 |
| 419 | 198 | $32,915.90 | 0 | $0.00 |
| 426 | 263 | $47,877.70 | 0 | $0.00 |
| 445 | 2 | $405.80 | 0 | $0.00 |
| 451 | 39 | $7,106.60 | 0 | $0.00 |
| 455 | 7 | $1,420.30 | 0 | $0.00 |
| 457 | 18 | $7,062.00 | 0 | $0.00 |
| 459 | 2 | $811.60 | 0 | $0.00 |
| 462 | 92 | $17,442.10 | 0 | $0.00 |
| 465 | 2 | $405.80 | 0 | $0.00 |
| 466 | 26 | $9,920.60 | 0 | $0.00 |
| 472 | 27 | $4,724.10 | 0 | $0.00 |
| 476 | 5 | $956.20 | 0 | $0.00 |
| 478 | 14 | $5,521.70 | 0 | $0.00 |
| 482 | 72 | $13,002.60 | 0 | $0.00 |
| 486 | 5 | $960.10 | 0 | $0.00 |
| 488 | 31 | $11,696.40 | 0 | $0.00 |
| 493 | 1 | $202.90 | 0 | $0.00 |
| **Plan Total:** | **21,726** | **$5,311,142.63** | **1** | **$51.50** |

**Medicare Part B Reimbursement and Penalty Report**
**PAY PERIOD 6/30/2026**

| Deduction Code | No. of Members | Reimbursement Amount | No. of Penalties | Penalty Amount |
|---|---|---|---|---|
| **SCAN** | | | | |
| 611 | 361 | $67,970.70 | 0 | $0.00 |
| 613 | 155 | $59,814.30 | 0 | $0.00 |
| 620 | 29 | $5,447.90 | 0 | $0.00 |
| 621 | 14 | $5,561.60 | 0 | $0.00 |
| 622 | 27 | $5,297.20 | 0 | $0.00 |
| 623 | 9 | $3,339.60 | 0 | $0.00 |
| **Plan Total:** | **595** | **$147,431.30** | **0** | **$0.00** |
| | | | | |
| **UNITED HEALTHCARE GROUP MEDICARE ADV. HMO** | | | | |
| 701 | 2285 | $435,171.40 | 0 | $0.00 |
| 702 | 418 | $80,770.00 | 0 | $0.00 |
| 703 | 1420 | $550,515.20 | 0 | $0.00 |
| 704 | 115 | $24,613.20 | 0 | $0.00 |
| 705 | 55 | $20,078.10 | 0 | $0.00 |
| **Plan Total:** | **4,293** | **$1,111,147.90** | **0** | **$0.00** |
| **Grand Total:** | **41,196** | **$10,298,161.69** | **1** | **$51.50** |

**Medicare Part B Reimbursement and Penalty Report**
**PAY PERIOD 6/30/2026**

| Deduction Code | No. of Members | Reimbursement Amount | No. of Penalties | Penalty Amount |
|---|---|---|---|---|
| **ANTHEM BC III** | | | | |
| 240 | 8042 | $1,500,732.60 | 0 | $0.00 |
| 241 | 133 | $24,051.00 | 0 | $0.00 |
| 242 | 1063 | $206,371.20 | 0 | $0.00 |
| 243 | 4933 | $1,888,424.96 | 0 | $0.00 |
| 244 | 14 | $2,437.40 | 0 | $0.00 |
| 245 | 67 | $12,642.00 | 0 | $0.00 |
| 246 | 12 | $2,255.70 | 0 | $0.00 |
| 247 | 193 | $38,857.30 | 0 | $0.00 |
| 248 | 13 | $4,250.20 | 0 | $0.00 |
| 249 | 96 | $42,460.50 | 0 | $0.00 |
| 250 | 16 | $5,957.00 | 0 | $0.00 |
| **Plan Total:** | **14,582** | **$3,728,439.86** | **0** | **$0.00** |
| | | | | |
| **KAISER SR. ADVANTAGE** | | | | |
| 394 | 24 | $4,432.60 | 0 | $0.00 |
| 397 | 2 | $347.50 | 0 | $0.00 |
| 398 | 14 | $5,681.20 | 0 | $0.00 |
| 403 | 12632 | $2,326,323.91 | 0 | $0.00 |
| 413 | 1646 | $322,581.10 | 0 | $0.00 |
| 418 | 6604 | $2,489,343.92 | 1 | $51.50 |
| 419 | 198 | $32,915.90 | 0 | $0.00 |
| 426 | 263 | $47,877.70 | 0 | $0.00 |
| 445 | 2 | $405.80 | 0 | $0.00 |
| 451 | 39 | $7,106.60 | 0 | $0.00 |
| 455 | 7 | $1,420.30 | 0 | $0.00 |
| 457 | 18 | $7,062.00 | 0 | $0.00 |
| 459 | 2 | $811.60 | 0 | $0.00 |
| 462 | 92 | $17,442.10 | 0 | $0.00 |
| 465 | 2 | $405.80 | 0 | $0.00 |
| 466 | 26 | $9,920.60 | 0 | $0.00 |
| 472 | 27 | $4,724.10 | 0 | $0.00 |
| 476 | 5 | $956.20 | 0 | $0.00 |
| 478 | 14 | $5,521.70 | 0 | $0.00 |
| 482 | 72 | $13,002.60 | 0 | $0.00 |
| 486 | 5 | $960.10 | 0 | $0.00 |
| 488 | 31 | $11,696.40 | 0 | $0.00 |
| 493 | 1 | $202.90 | 0 | $0.00 |
| **Plan Total:** | **21,726** | **$5,311,142.63** | **1** | **$51.50** |

**Medicare Part B Reimbursement and Penalty Report**
**PAY PERIOD 6/30/2026**

| Deduction Code | No. of Members | Reimbursement Amount | No. of Penalties | Penalty Amount |
|---|---|---|---|---|
| **SCAN** | | | | |
| 611 | 361 | $67,970.70 | 0 | $0.00 |
| 613 | 155 | $59,814.30 | 0 | $0.00 |
| 620 | 29 | $5,447.90 | 0 | $0.00 |
| 621 | 14 | $5,561.60 | 0 | $0.00 |
| 622 | 27 | $5,297.20 | 0 | $0.00 |
| 623 | 9 | $3,339.60 | 0 | $0.00 |
| **Plan Total:** | **595** | **$147,431.30** | **0** | **$0.00** |
| | | | | |
| **UNITED HEALTHCARE GROUP MEDICARE ADV. HMO** | | | | |
| 701 | 2285 | $435,171.40 | 0 | $0.00 |
| 702 | 418 | $80,770.00 | 0 | $0.00 |
| 703 | 1420 | $550,515.20 | 0 | $0.00 |
| 704 | 115 | $24,613.20 | 0 | $0.00 |
| 705 | 55 | $20,078.10 | 0 | $0.00 |
| **Plan Total:** | **4,293** | **$1,111,147.90** | **0** | **$0.00** |
| | | | | |
| **LOCAL 1014** | | | | |
| 804 | 211 | $59,306.80 | 0 | $0.00 |
| 805 | 251 | $59,530.30 | 0 | $0.00 |
| 806 | 790 | $357,429.00 | 0 | $0.00 |
| 807 | 64 | $13,553.80 | 0 | $0.00 |
| 808 | 26 | $14,040.60 | 0 | $0.00 |
| 812 | 269 | $60,626.45 | 0 | $0.00 |
| 813 | 2 | $405.80 | 0 | $0.00 |
| 814 | 1 | $202.90 | 0 | $0.00 |
| **Plan Total:** | **1,614** | **$565,095.65** | **0** | **$0.00** |
| **Grand Total:** | **42,810** | **$10,863,257.34** | **1** | **$51.50** |

# Medical and Dental Vision Insurance Premiums

## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **Medical Plan** | | | | | | | |
| **Anthem Blue Cross Prudent Buyer Plan** | | | | | | | |
| 201 | 386 | $487,622.88 | $68,644.01 | $416,392.59 | $485,036.60 | $0.00 | $485,036.60 |
| 202 | 204 | $509,699.62 | $43,849.73 | $455,880.98 | $499,730.71 | $0.00 | $499,730.71 |
| 203 | 76 | $215,027.89 | $29,943.49 | $195,849.18 | $225,792.67 | $2,711.47 | $228,504.14 |
| 204 | 26 | $42,009.24 | $9,565.22 | $35,535.04 | $45,100.26 | $1,568.92 | $46,669.18 |
| **SUBTOTAL** | **692** | **$1,254,359.63** | **$152,002.45** | **$1,103,657.79** | **$1,255,660.24** | **$4,280.39** | **$1,259,940.63** |
| **Anthem Blue Cross I** | | | | | | | |
| 211 | 485 | $845,484.40 | $50,382.49 | $799,413.06 | $849,795.55 | $0.00 | $849,795.55 |
| 212 | 211 | $662,487.28 | $37,061.84 | $621,766.42 | $658,828.26 | ($2,857.90) | $655,970.36 |
| 213 | 75 | $280,169.44 | $23,666.94 | $246,073.46 | $269,740.40 | $0.00 | $269,740.40 |
| 214 | 27 | $61,907.49 | $5,044.28 | $61,057.45 | $66,101.73 | $0.00 | $66,101.73 |
| 215 | 2 | $1,168.68 | $186.99 | $981.69 | $1,168.68 | $0.00 | $1,168.68 |
| **SUBTOTAL** | **800** | **$1,851,217.29** | **$116,342.54** | **$1,729,292.08** | **$1,845,634.62** | **($2,857.90)** | **$1,842,776.72** |
| **Anthem Blue Cross II** | | | | | | | |
| 221 | 2,519 | $4,379,886.40 | $209,993.81 | $4,201,950.94 | $4,411,944.75 | $1,584.80 | $4,413,529.55 |
| 222 | 2,104 | $6,631,122.68 | $152,119.64 | $6,375,390.30 | $6,527,509.94 | ($12,419.30) | $6,515,090.64 |
| 223 | 1,017 | $3,763,855.24 | $140,861.93 | $3,666,094.69 | $3,806,956.62 | $3,371.30 | $3,810,327.92 |
| 224 | 273 | $625,953.51 | $61,874.21 | $574,173.40 | $636,047.61 | $4,194.24 | $640,241.85 |
| 225 | 1 | $584.34 | $0.00 | $584.34 | $584.34 | $0.00 | $584.34 |
| **SUBTOTAL** | **5,914** | **$15,401,402.17** | **$564,849.59** | **$14,818,193.67** | **$15,383,043.26** | **($3,268.96)** | **$15,379,774.30** |

# Medical and Dental Vision Insurance Premiums
## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **Anthem Blue Cross III** | | | | | | | |
| 240 | 8,090 | $5,686,549.44 | $702,784.77 | $5,031,316.29 | $5,734,101.06 | ($10,929.30) | $5,723,171.76 |
| 241 | 132 | $299,158.23 | $21,188.46 | $273,663.17 | $294,851.63 | ($2,057.29) | $292,794.34 |
| 242 | 1,057 | $2,404,512.39 | $122,599.10 | $2,268,746.54 | $2,391,345.64 | $4,114.58 | $2,395,460.22 |
| 243 | 4,952 | $6,947,763.32 | $688,914.72 | $6,233,593.24 | $6,922,507.96 | ($7,682.46) | $6,914,825.50 |
| 244 | 14 | $17,626.14 | $1,460.44 | $16,165.70 | $17,626.14 | $0.00 | $17,626.14 |
| 245 | 66 | $85,612.68 | $6,340.54 | $76,754.12 | $83,094.66 | $0.00 | $83,094.66 |
| 246 | 13 | $36,474.62 | $2,356.83 | $31,312.05 | $33,668.88 | ($2,566.05) | $31,102.83 |
| 247 | 198 | $563,953.74 | $28,603.91 | $520,362.37 | $548,966.28 | $0.00 | $548,966.28 |
| 248 | 13 | $25,427.61 | $1,916.84 | $23,510.77 | $25,427.61 | $0.00 | $25,427.61 |
| 249 | 97 | $189,729.09 | $14,865.36 | $192,587.64 | $207,453.00 | $0.00 | $207,453.00 |
| 250 | 16 | $35,076.00 | $2,849.92 | $32,226.08 | $35,076.00 | $0.00 | $35,076.00 |
| **SUBTOTAL** | **14,648** | **$16,291,883.26** | **$1,593,880.89** | **$14,700,237.97** | **$16,294,118.86** | **($19,120.52)** | **$16,274,998.34** |
| **CIGNA Network Model Plan** | | | | | | | |
| 301 | 197 | $450,560.88 | $114,461.70 | $325,217.96 | $439,679.66 | ($2,027.27) | $437,652.39 |
| 302 | 50 | $205,514.50 | $52,954.93 | $152,559.57 | $205,514.50 | $0.00 | $205,514.50 |
| 303 | 7 | $33,974.78 | $8,034.80 | $21,086.44 | $29,121.24 | $0.00 | $29,121.24 |
| 304 | 11 | $33,219.01 | $12,399.73 | $20,819.28 | $33,219.01 | $0.00 | $33,219.01 |
| **SUBTOTAL** | **265** | **$723,269.17** | **$187,851.16** | **$519,683.25** | **$707,534.41** | **($2,027.27)** | **$705,507.14** |

# Medical and Dental Vision Insurance Premiums
## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **Kaiser/Senior Advantage** | | | | | | | |
| 401 | 1,718 | $3,021,698.69 | $194,621.55 | $2,852,500.40 | $3,047,121.95 | $7,053.85 | $3,054,175.80 |
| 403 | 12,644 | $3,867,226.47 | $329,121.74 | $3,577,800.82 | $3,906,922.56 | ($4,666.56) | $3,902,256.00 |
| 404 | 431 | $744,651.36 | $10,489.94 | $744,384.26 | $754,874.20 | ($9,513.01) | $745,361.19 |
| 405 | 1,489 | $2,571,805.16 | $19,891.92 | $2,543,913.39 | $2,563,805.31 | $0.00 | $2,563,805.31 |
| 411 | 2,064 | $6,439,386.00 | $242,597.81 | $6,151,677.03 | $6,394,274.84 | $8,440.62 | $6,402,715.46 |
| 413 | 1,619 | $2,725,405.20 | $113,913.11 | $2,601,747.91 | $2,715,661.02 | $1,694.43 | $2,717,355.45 |
| 414 | 45 | $137,790.00 | $367.44 | $137,130.36 | $137,497.80 | ($575.32) | $136,922.48 |
| 418 | 6,562 | $3,970,602.36 | $275,720.71 | $3,689,120.82 | $3,964,841.53 | ($5,753.20) | $3,959,088.33 |
| 419 | 202 | $412,133.04 | $5,414.27 | $397,726.18 | $403,140.45 | $0.00 | $403,140.45 |
| 420 | 89 | $272,518.00 | $1,469.76 | $271,048.24 | $272,518.00 | $0.00 | $272,518.00 |
| 421 | 9 | $15,513.57 | $620.55 | $14,893.02 | $15,513.57 | $0.00 | $15,513.57 |
| 422 | 270 | $838,988.00 | $3,184.48 | $817,921.32 | $821,105.80 | $0.00 | $821,105.80 |
| 426 | 260 | $533,348.64 | $5,252.65 | $513,222.99 | $518,475.64 | $0.00 | $518,475.64 |
| 428 | 39 | $119,418.00 | $612.40 | $118,805.60 | $119,418.00 | $0.00 | $119,418.00 |
| 430 | 140 | $431,742.00 | $2,143.40 | $418,074.62 | $420,218.02 | $0.00 | $420,218.02 |
| **SUBTOTAL** | **27,581** | **$26,102,226.49** | **$1,205,421.73** | **$24,849,966.96** | **$26,055,388.69** | **($3,319.19)** | **$26,052,069.50** |
| **Kaiser - Colorado** | | | | | | | |
| 450 | 5 | $7,109.00 | $284.36 | $6,824.64 | $7,109.00 | $0.00 | $7,109.00 |
| 451 | 40 | $11,916.00 | $1,483.54 | $10,432.46 | $11,916.00 | $0.00 | $11,916.00 |
| 453 | 9 | $28,321.11 | $571.64 | $27,749.47 | $28,321.11 | $0.00 | $28,321.11 |
| 455 | 7 | $11,981.90 | $924.32 | $11,057.58 | $11,981.90 | $0.00 | $11,981.90 |
| 457 | 18 | $10,580.40 | $1,034.53 | $9,545.87 | $10,580.40 | $0.00 | $10,580.40 |
| 459 | 2 | $4,003.20 | $80.06 | $3,923.14 | $4,003.20 | $0.00 | $4,003.20 |
| **SUBTOTAL** | **81** | **$73,911.61** | **$4,378.45** | **$69,533.16** | **$73,911.61** | **$0.00** | **$73,911.61** |

# Medical and Dental Vision Insurance Premiums

## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **Kaiser - Georgia** | | | | | | | |
| 440 | 1 | $1,780.87 | $48.32 | $1,732.55 | $1,780.87 | $0.00 | $1,780.87 |
| 441 | 3 | $5,342.61 | $144.96 | $5,197.65 | $5,342.61 | $0.00 | $5,342.61 |
| 442 | 6 | $10,685.22 | $289.92 | $10,395.30 | $10,685.22 | $0.00 | $10,685.22 |
| 445 | 2 | $4,399.46 | $0.00 | $4,399.46 | $4,399.46 | $0.00 | $4,399.46 |
| 461 | 15 | $26,713.05 | $2,353.39 | $24,359.66 | $26,713.05 | $0.00 | $26,713.05 |
| 462 | 92 | $39,271.12 | $5,113.78 | $34,157.34 | $39,271.12 | ($413.87) | $38,857.25 |
| 463 | 4 | $14,214.96 | $3,277.67 | $10,937.29 | $14,214.96 | $0.00 | $14,214.96 |
| 465 | 2 | $4,399.46 | $0.00 | $4,399.46 | $4,399.46 | $0.00 | $4,399.46 |
| 466 | 26 | $21,988.72 | $1,370.07 | $20,618.65 | $21,988.72 | $0.00 | $21,988.72 |
| **SUBTOTAL** | **151** | **$128,795.47** | **$12,598.11** | **$116,197.36** | **$128,795.47** | **($413.87)** | **$128,381.60** |
| **Kaiser - Hawaii** | | | | | | | |
| 471 | 7 | $7,423.99 | $636.34 | $6,787.65 | $7,423.99 | $0.00 | $7,423.99 |
| 472 | 26 | $12,136.23 | $1,708.35 | $9,531.14 | $11,239.49 | $0.00 | $11,239.49 |
| 474 | 3 | $6,339.42 | $0.00 | $6,339.42 | $6,339.42 | $0.00 | $6,339.42 |
| 475 | 2 | $6,331.42 | $0.00 | $6,331.42 | $6,331.42 | $0.00 | $6,331.42 |
| 476 | 5 | $7,510.30 | $660.91 | $6,849.39 | $7,510.30 | $0.00 | $7,510.30 |
| 478 | 14 | $12,473.72 | $605.86 | $11,867.86 | $12,473.72 | $0.00 | $12,473.72 |
| **SUBTOTAL** | **57** | **$52,215.08** | **$3,611.46** | **$47,706.88** | **$51,318.34** | **$0.00** | **$51,318.34** |

# Medical and Dental Vision Insurance Premiums

## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **Kaiser - Oregon** | | | | | | | |
| 481 | 8 | $12,943.04 | $388.29 | $12,554.75 | $12,943.04 | $0.00 | $12,943.04 |
| 482 | 74 | $45,122.24 | $5,768.30 | $39,353.94 | $45,122.24 | $0.00 | $45,122.24 |
| 484 | 3 | $9,683.28 | $308.46 | $9,374.82 | $9,683.28 | $0.00 | $9,683.28 |
| 486 | 5 | $11,098.20 | $0.00 | $11,098.20 | $11,098.20 | $0.00 | $11,098.20 |
| 488 | 31 | $37,557.12 | $5,185.31 | $32,371.81 | $37,557.12 | $0.00 | $37,557.12 |
| 493 | 1 | $3,829.52 | $143.08 | $3,686.44 | $3,829.52 | $0.00 | $3,829.52 |
| **SUBTOTAL** | **122** | **$120,233.40** | **$11,793.44** | **$108,439.96** | **$120,233.40** | **$0.00** | **$120,233.40** |
| **SCAN Health Plan** | | | | | | | |
| 611 | 362 | $104,765.95 | $18,766.45 | $85,713.03 | $104,479.48 | ($287.31) | $104,192.17 |
| 613 | 155 | $87,739.30 | $13,970.33 | $74,335.59 | $88,305.92 | ($566.62) | $87,739.30 |
| **SUBTOTAL** | **517** | **$192,505.25** | **$32,736.78** | **$160,048.62** | **$192,785.40** | **($853.93)** | **$191,931.47** |
| **SCAN Health Plan, AZ** | | | | | | | |
| 620 | 29 | $8,323.87 | $1,153.87 | $7,457.31 | $8,611.18 | $0.00 | $8,611.18 |
| 621 | 14 | $7,924.84 | $1,369.86 | $6,554.98 | $7,924.84 | $0.00 | $7,924.84 |
| **SUBTOTAL** | **43** | **$16,248.71** | **$2,523.73** | **$14,012.29** | **$16,536.02** | **$0.00** | **$16,536.02** |
| **SCAN Health Plan, NV** | | | | | | | |
| 622 | 28 | $8,036.84 | $1,268.68 | $6,768.16 | $8,036.84 | $0.00 | $8,036.84 |
| 623 | 9 | $5,094.54 | $633.98 | $4,460.56 | $5,094.54 | $0.00 | $5,094.54 |
| **SUBTOTAL** | **37** | **$13,131.38** | **$1,902.66** | **$11,228.72** | **$13,131.38** | **$0.00** | **$13,131.38** |

# Medical and Dental Vision Insurance Premiums

## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **UHC Medicare Adv.** | | | | | | | |
| 701 | 2,283 | $992,823.14 | $108,931.16 | $892,393.56 | $1,001,324.72 | $1,937.25 | $1,003,261.97 |
| 702 | 410 | $981,754.71 | $43,585.61 | $917,081.29 | $960,666.90 | $0.00 | $960,666.90 |
| 703 | 1,413 | $1,219,161.16 | $113,188.47 | $1,107,453.85 | $1,220,642.32 | $0.00 | $1,220,642.32 |
| 704 | 117 | $315,312.52 | $8,711.20 | $312,787.20 | $321,498.40 | $0.00 | $321,498.40 |
| 705 | 53 | $65,285.55 | $4,350.57 | $57,503.16 | $61,853.73 | $0.00 | $61,853.73 |
| **SUBTOTAL** | **4,276** | **$3,574,337.08** | **$278,767.01** | **$3,287,219.06** | **$3,565,986.07** | **$1,937.25** | **$3,567,923.32** |
| **United Healthcare** | | | | | | | |
| 706 | 2 | $1,092.06 | $65.52 | $1,026.54 | $1,092.06 | $0.00 | $1,092.06 |
| 707 | 541 | $1,060,714.83 | $159,592.86 | $866,817.40 | $1,026,410.26 | $0.00 | $1,026,410.26 |
| 708 | 455 | $1,633,660.86 | $218,545.35 | $1,328,021.45 | $1,546,566.80 | $0.00 | $1,546,566.80 |
| 709 | 332 | $1,409,314.53 | $204,804.16 | $1,155,104.10 | $1,359,908.26 | $0.00 | $1,359,908.26 |
| **SUBTOTAL** | **1,330** | **$4,104,782.28** | **$583,007.89** | **$3,350,969.49** | **$3,933,977.38** | **$0.00** | **$3,933,977.38** |

# Medical and Dental Vision Insurance Premiums

## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **Local 1014 Firefighters** | | | | | | | |
| 801 | 86 | $130,182.50 | $6,509.12 | $121,164.59 | $127,673.71 | $0.00 | $127,673.71 |
| 802 | 344 | $938,913.60 | $30,787.63 | $905,396.57 | $936,184.20 | $0.00 | $936,184.20 |
| 803 | 442 | $1,423,058.78 | $49,130.90 | $1,388,131.48 | $1,437,262.38 | $6,175.48 | $1,443,437.86 |
| 804 | 211 | $319,401.25 | $9,627.43 | $309,773.82 | $319,401.25 | ($59,306.80) | $260,094.45 |
| 805 | 252 | $687,808.80 | $19,870.03 | $665,209.37 | $685,079.40 | ($59,530.30) | $625,549.10 |
| 806 | 791 | $2,158,955.40 | $45,253.48 | $2,108,564.30 | $2,153,817.78 | ($362,664.26) | $1,791,153.52 |
| 807 | 64 | $206,053.76 | $2,318.10 | $203,735.66 | $206,053.76 | ($13,553.80) | $192,499.96 |
| 808 | 26 | $83,709.34 | $2,060.54 | $84,489.52 | $86,550.06 | ($14,040.60) | $72,509.46 |
| 809 | 14 | $21,192.50 | $908.25 | $20,284.25 | $21,192.50 | $0.00 | $21,192.50 |
| 810 | 9 | $24,564.60 | $3,220.69 | $21,343.91 | $24,564.60 | $0.00 | $24,564.60 |
| 811 | 5 | $16,097.95 | $1,931.76 | $14,166.19 | $16,097.95 | $0.00 | $16,097.95 |
| 812 | 271 | $410,226.25 | $23,341.96 | $388,336.05 | $411,678.01 | ($61,352.33) | $350,325.68 |
| 813 | 2 | $5,458.80 | $0.00 | $5,458.80 | $5,458.80 | ($405.80) | $5,053.00 |
| 814 | 1 | $3,219.59 | $1,030.27 | $2,189.32 | $3,219.59 | ($202.90) | $3,016.69 |
| **SUBTOTAL** | **2,518** | **$6,428,843.12** | **$195,990.16** | **$6,238,243.83** | **$6,434,233.99** | **($564,881.31)** | **$5,869,352.68** |
| **Kaiser - Washington** | | | | | | | |
| 393 | 5 | $10,967.65 | $2,304.90 | $8,662.75 | $10,967.65 | $0.00 | $10,967.65 |
| 394 | 24 | $10,818.72 | $1,343.31 | $9,475.41 | $10,818.72 | $0.00 | $10,818.72 |
| 395 | 1 | $4,089.26 | $964.32 | $3,124.94 | $4,089.26 | $0.00 | $4,089.26 |
| 397 | 2 | $4,693.02 | $0.00 | $4,693.02 | $4,693.02 | $0.00 | $4,693.02 |
| 398 | 14 | $12,509.84 | $1,286.72 | $11,223.12 | $12,509.84 | $0.00 | $12,509.84 |
| **SUBTOTAL** | **46** | **$43,078.49** | **$5,899.25** | **$37,179.24** | **$43,078.49** | **$0.00** | **$43,078.49** |
| **Medical Plan Total** | **59,078** | **$76,372,439.88** | **$4,953,557.30** | **$71,161,810.33** | **$76,115,367.63** | **($590,525.31)** | **$75,524,842.32** |

# Medical and Dental Vision Insurance Premiums

## July 2026

| Carrier Codes | Member Count | Premium Amount | Member Amount | County Subsidy Amount | Total | Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|
| **Dental/Vision Plan** | | | | | | | |
| **CIGNA Indemnity Dental/Vision** | | | | | | | |
| 501 | 27,871 | $1,568,083.68 | $153,489.10 | $1,433,540.36 | $1,587,029.46 | ($1,236.40) | $1,585,793.06 |
| 502 | 25,651 | $3,029,288.90 | $222,006.86 | $2,825,546.84 | $3,047,553.70 | ($3,978.34) | $3,043,575.36 |
| 503 | 12 | $832.20 | $27.74 | $804.46 | $832.20 | $0.00 | $832.20 |
| **SUBTOTAL** | **53,534** | **$4,598,204.78** | **$375,523.70** | **$4,259,891.66** | **$4,635,415.36** | **($5,214.74)** | **$4,630,200.62** |
| **CIGNA Dental HMO/Vision** | | | | | | | |
| 901 | 4,546 | $212,446.28 | $21,000.28 | $193,263.10 | $214,263.38 | $279.60 | $214,542.98 |
| 902 | 3,451 | $330,724.86 | $22,861.18 | $312,062.60 | $334,923.78 | ($95.45) | $334,828.33 |
| 903 | 3 | $141.78 | $18.90 | $122.88 | $141.78 | $0.00 | $141.78 |
| **SUBTOTAL** | **8,000** | **$543,312.92** | **$43,880.36** | **$505,448.58** | **$549,328.94** | **$184.15** | **$549,513.09** |
| **Dental/Vision Plan Total** | **61,534** | **$5,141,517.70** | **$419,404.06** | **$4,765,340.24** | **$5,184,744.30** | **($5,030.59)** | **$5,179,713.71** |
| **GRAND TOTALS** | **120,612** | **$81,513,957.58** | **$5,372,961.36** | **$75,927,150.57** | **$81,300,111.93** | **($595,555.90)** | **$80,704,556.03** |

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| **Anthem Blue Cross Prudent Buyer Plan** | | |
| $1,220.38 | 201 | Retiree Only |
| $2,402.44 | 202 | Retiree and Spouse/Domestic Partner |
| $2,711.47 | 203 | Retiree, Spouse/Domestic Partner and Children |
| $1,568.92 | 204 | Retiree and Children |
| $331.92 | 205 | Survivor Children Only Rates |
| **Anthem Blue Cross Plan I** | | |
| **$1,584.80** | 211 | Retiree Only |
| **$2,857.90** | 212 | Retiree and Spouse/Domestic Partner |
| **$3,371.30** | 213 | Retiree, Spouse/Domestic Partner and Children |
| **$2,097.12** | 214 | Retiree and Children |
| $534.96 | 215 | Survivor Children Only Rates |
| **Anthem Blue Cross Plan II** | | |
| **$1,584.80** | 221 | Retiree Only |
| **$2,857.90** | 222 | Retiree and Spouse/Domestic Partner |
| **$3,371.30** | 223 | Retiree, Spouse/Domestic Partner and Children |
| **$2,097.12** | 224 | Retiree and Children |
| $534.96 | 225 | Survivor Children Only Rates |
| **Anthem Blue Cross Plan III** | | |
| $642.90 | 240 | Retiree Only with Medicare |
| $2,057.29 | 241 | Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross I) |
| $2,057.29 | 242 | Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross II) |
| $1,280.41 | 243 | Retiree and Spouse/Domestic Partner - Both with Medicare |
| $1,151.83 | 244 | Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross I) |
| $1,151.83 | 245 | Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross II) |
| $2,566.05 | 246 | Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross I) |
| $2,566.05 | 247 | Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross II) |
| $1,789.08 | 248 | Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross I) |
| $1,789.08 | 249 | Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross II) |
| $2,005.12 | 250 | Member, Spouse/Domestic Partner, Child (3 with Medicare) |

***Benchmark premiums are bolded.**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| **CIGNA Network Model Plan** | | |
| $2,027.27 | 301 | Retiree Only |
| $3,661.10 | 302 | Retiree and Spouse/Domestic Partner |
| $4,323.07 | 303 | Retiree, Spouse/Domestic Partner and Children |
| $2,690.19 | 304 | Retiree and Children |
| $670.42 | 305 | Survivor Children Only Rates |
| **Kaiser** | | |
| $1,410.77 | 401 | Retiree Only ("Basic") |
| $291.66 | 403 | Retiree Only ("Senior Advantage") |
| $1,367.03 | 404 | Retiree Only ("Excess I") *"Closed to New Entrants"* |
| $1,414.33 | 405 | Retiree Only - ("Excess II") |
| $2,813.54 | 411 | Retiree and Family (All family members are "Basic") |
| $1,694.43 | 413 | Retiree and Family (One family member is "Senior Advantage"; others are "Basic") |
| $2,769.80 | 414 | Retiree and Family (One family member is "Excess I"; others are "Basic") *"Closed to New Entrants"* |
| $575.32 | 418 | Retiree and Family (Two or more family members are "Senior Advantage") |
| $1,650.69 | 419 | Retiree and Family (One family member is "Excess I"; others are "Senior Advantage" *"Closed to New Entrants"* |
| $2,726.06 | 420 | Retiree and Family (Two or more family members are "Excess I") *"Closed to New Entrants"* |
| N/A | 421 | Survivor Children Only Rates |
| $2,817.10 | 422 | Retiree and Family (One family member is "Excess II"; others are "Basic") |
| $1,697.99 | 426 | Retiree and Family (One family member is "Senior Advantage"; others are "Excess II") |
| $2,773.36 | 428 | Retiree and Family (One family member is "Excess I"; others are "Excess II") |
| $2,820.66 | 430 | Retiree and Family (Two or more family members are "Excess II") |
| **Kaiser Colorado** | | |
| $1,421.80 | 450 | Retiree Only ("Basic" under age 65) |
| $297.90 | 451 | Retiree Only ("Senior Advantage") |
| $3,146.79 | 453 | Retiree and Family (Two family members are "Basic") |
| $4,249.55 | 454 | Retiree and Family (Three or more family members are "Basic") |
| $1,711.70 | 455 | Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic") |
| $587.80 | 457 | Retiree and Family (Two family members are "Senior Advantage") |
| $3,043.28 | 458 | Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic") |
| $2,001.60 | 459 | Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic") |

***Benchmark premiums are bolded.**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| **Kaiser Georgia** | | |
| $1,780.87 | 440 | Retiree Only ("Basic" over age 65 with Medicare Part B only |
| $1,780.87 | 441 | Retiree Only ("Basic over age 65 with Medicare Part A only) |
| $1,780.87 | 442 | Retiree Only ("Basic over age 65 without Medicare Part A or Medicare Part B) |
| $413.87 | 443 | Retiree Only ("Basic" over age 65 - Medicare eligible who is classified as having renal failure) |
| $2,186.74 | 444 | Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part B only) |
| $2,186.74 | 445 | Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part A only) |
| $2,186.74 | 446 | Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 without Medicare Part A and B) |
| $1,780.87 | 461 | Retiree Only ("Basic" under age 65) |
| $413.87 | 462 | Retiree Only ("Senior Advantage") |
| $3,553.74 | 463 | Retiree and Family (Two family members are "Basic") |
| $5,326.61 | 464 | Retiree and Family (Three or more family members are "Basic) |
| $2,186.74 | 465 | Retiree and Family (One family member is "Senior Advantage"; one is "Basic") |
| $819.74 | 466 | Retiree and Family (Two family members are "Senior Advantage") |
| $3,959.61 | 467 | Retiree and Family ( One family member is "Senior Advantage"; two or more are "Basic") |
| $2,592.61 | 468 | Retiree and Family (Two family members are "Senior Advantage"; one is "Basic") |
| $1,225.61 | 469 | Retiree and Family (Three or more family members are "Senior Advantage"; one is "Basic") |
| $3,959.61 | 470 | Retiree and Family (Three or more family members are "Basic"; one is "Senior Advantage" |
| **Kaiser Hawaii** | | |
| $962.84 | 471 | Retiree Only ("Basic" under age 65) |
| $447.25 | 472 | Retiree Only ("Senior Advantage") |
| $2,222.50 | 473 | Retiree Only (Over age 65 without Medicare Part A or Medicare Part B) |
| $1,917.68 | 474 | Retiree and Family (Two family members are "Basic") |
| $2,872.52 | 475 | Retiree and Family (Three or more family members are "Basic") |
| $1,402.09 | 476 | Retiree and Family (One family member is "Senior Advantage"; one is "Basic") |
| $3,177.34 | 477 | Retiree and Family (One family member is "Basic" under age 65; one is over age 65 without Medicare Part A or Medicare Part B) |
| $886.50 | 478 | Retiree and Family (Two family members are "Senior Advantage" |
| $2,661.75 | 479 | Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B) |

***Benchmark premiums are bolded.**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| **Kaiser Oregon** | | |
| $1,414.96 | 481 | Retiree Only ("Basic" under age 65) |
| $565.20 | 482 | Retiree Only ("Senior Advantage") |
| $1,732.21 | 483 | Retiree Only (Over age 65 without Medicare Part A or Medicare Part B) |
| $2,821.92 | 484 | Retiree and Family (Two family members are "Basic") |
| $4,228.88 | 485 | Retiree and Family (Three or more family members are "Basic") |
| $1,972.16 | 486 | Retiree and Family (One family member is "Senior Advantage"; one is "Basic") |
| $1,122.40 | 488 | Retiree and Family (Two family members are "Senior Advantage") |
| $1,732.21 | 490 | Retiree Only (Over age 65 with Medicare Part B only) |
| $1,930.86 | 491 | Retiree and Family (One family member is "Senior Advantage"; one is over age 65 with Medicare Par A only) |
| $2,289.41 | 492 | Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B) |
| $3,379.12 | 493 | Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic") |
| $2,529.36 | 494 | Retiree and Family (Two family members are "Senior Advantage"; one is "Basic") |
| $3,456.42 | 495 | Retiree and Family (Two family members are over age 65 without Medicare Part A or Medicare Part B) |
| $2,739.32 | 496 | Retiree and Family (Two family members are over age 65 with Medicare Part A only) |
| $2,780.62 | 497 | Retiree and Family (One family member is "Basic"; one is over age 65 with Medicare Part A only) |
| $3,139.17 | 498 | Retiree and Family (One family member is "Basic"; one is over age 65 without Medicare Part A or Medicare Part B) |
| **Kaiser Washington** | | |
| $2,012.53 | 393 | Retiree and Family ("Basic" under age 65) |
| $417.92 | 394 | Retiree Only ("Senior Advantage") |
| $3,751.26 | 395 | Retiree and Family (Two family members are "Basic") |
| $6,275.96 | 396 | Retiree and Family (Three or more family members are "Basic") |
| $2,156.64 | 397 | Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic") |
| $827.82 | 398 | Retiree and Family (Two family members are "Senior Advantage") |
| $4,681.34 | 399 | Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic") |
| $3,352.52 | 400 | Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic") |

***Benchmark premiums are bolded.**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|

**Kaiser Rate Category Definitions**

**"Basic"** - includes those who are under age 65

**"Senior Advantage"**

-Includes participants who are age 65 or older and who have assigned both Medicare Part A and Part B to Kaiser.

**"Excess II"**

-Is for participants in the Excess Plan who either have Medicare Part B only or are not eligible for Medicare.

***Benchmark premiums are bolded.**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| **SCAN Health Plan** | | |
| $287.31 | 611 | Retiree Only with SCAN |
| $566.62 | 613 | Retiree and 1 Dependent - Both with SCAN (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child. Both Retiree and Dependent must have Medicare.) |
| **SCAN Health Plan – Arizona (Maricopa, Pima, Pinal Counties)** | | |
| $287.31 | 620 | Retiree Only |
| $566.62 | 621 | Retiree and Spouse/Domestic Partner or Retiree and One Child. Both Retiree and eligible dependent must be enrolled in Medicare Parts A & B. |
| **SCAN Health Plan – Nevada (Nye and Clark Counties)** | | |
| $287.31 | 622 | Retiree Only |
| $566.82 | 623 | Retiree and Spouse/Domestic Partner or Retiree and One Child. Both Retiree and eligible dependent must be enrolled in Medicare Parts A & B |
| **United Healthcare Medicare Advantage (UHCMA)** (For both members and dependents who are enrolled in UHCMA, or a family combination of UHCMA/UHC) | | |
| $387.45 | 701 | Retiree Only with Secure Horizons |
| $2,076.15 | 702 | Retiree and 1 Dependent - One with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child) |
| $766.90 | 703 | Retiree and 1 Dependent - Both with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child) |
| $2,367.05 | 704 | Retiree and 2 or More Dependents - One with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children) |
| $1,057.80 | 705 | Retiree and 2 or More Dependents - Two with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children) |
| $483.66 | 706 | Survivor Children Only Rates |

***Benchmark premiums are bolded.**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|

**United Healthcare (UHC)**
(For members and dependents under age 65 [no Medicare])

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| $1,696.70 | 707 | Retiree Only |
| $3,100.27 | 708 | Retiree and 1 Dependent |
| $3,676.30 | 709 | Retiree and 2 Or More Dependents |

**Local 1014 Firefighters**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| $1,451.76 | 801 | Member Under 65 |
| $2,617.63 | 802 | Member + 1 Under 65 |
| $3,087.74 | 803 | Member + 2 Under 65 |
| $1,451.76 | 804 | Member with Medicare |
| $2,617.63 | 805 | Member + 1; 1 Medicare |
| $2,617.63 | 806 | Member + 1; 2 Medicare |
| $3,087.74 | 807 | Member + 2; 1 Medicare |
| $3,087.74 | 808 | Member + 2; 2 Medicare |
| $1,451.76 | 809 | Surviving Spouse Under 65 |
| $2,617.63 | 810 | Surviving Spouse + 1; Under 65 |
| $3,087.74 | 811 | Surviving Spouse + 2 Under 65 |
| $1,451.76 | 812 | Surviving Spouse with Medicare |
| $2,617.63 | 813 | Surviving Spouse + 1; 1 Medicare |
| $3,087.74 | 814 | Spouse + 1; 1 Medicare |
| $2,617.63 | 815 | Surviving Spouse + 1; 2 Medicare |

**CIGNA Indemnity - Dental/Vision**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| **$56.20** | 501 | Retiree Only |
| **$117.86** | 502 | Retiree and Dependent(s) |
| $69.30 | 503 | Survivor Children Only Rates |

**CIGNA HMO - Dental/Vision**

| PREMIUMS* | CARRIER DEDUCTION CODES | DEDUCTION CODE DEFINITIONS |
|---|---|---|
| $46.60 | 901 | Retiree Only |
| $95.45 | 902 | Retiree and Dependent(s) |
| $47.21 | 903 | Survivor Children Only Rates |

***Benchmark premiums are bolded.**

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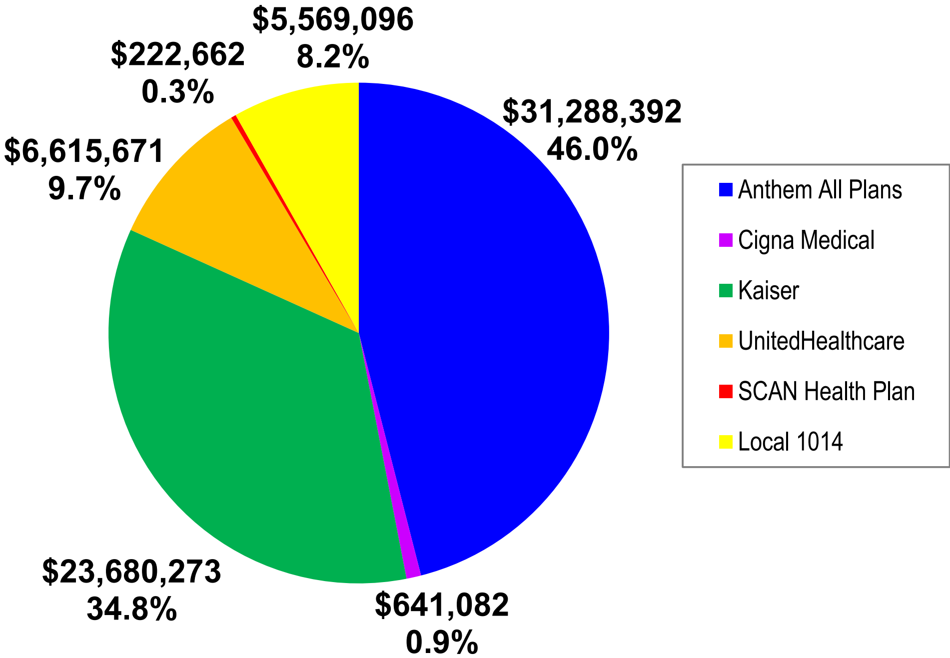
# Los Angeles County Employees Retirement Association

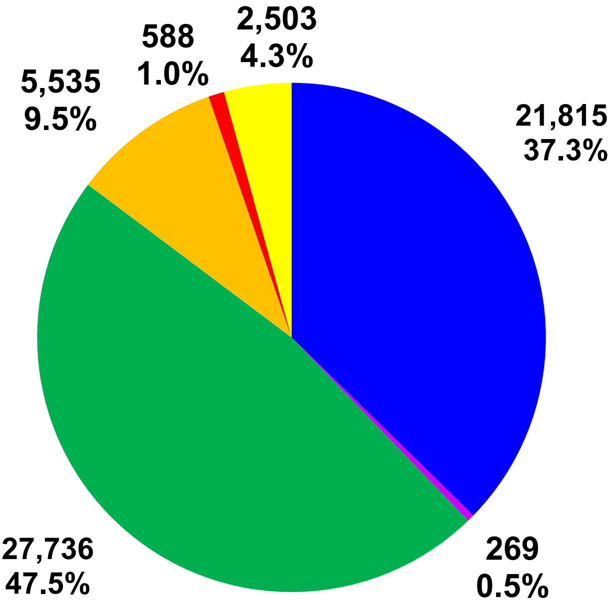
## Premium & Enrollment

*Coverage Month Ending May 2026*

| Carrier / Plan | Monthly Premium | Percent of Total | Retirees | Percent of Total |
|---|---|---|---|---|
| Anthem All Plans | $31,288,392 | 46.0% | 21,815 | 37.3% |
| Cigna Medical | $641,082 | 1.0% | 269 | 0.5% |
| Kaiser | $23,680,273 | 34.8% | 27,736 | 47.4% |
| UnitedHealthcare | $6,615,671 | 9.7% | 5,535 | 9.5% |
| SCAN Health Plan | $222,662 | 0.3% | 588 | 1.0% |
| Local 1014 | $5,569,096 | 8.2% | 2,503 | 4.3% |
| **Combined Medical** | **$68,017,175** | **100.0%** | **58,446** | **100.0%** |

| Carrier / Plan | Monthly Premium | Retirees |
|---|---|---|
| **Cigna Dental & Vision (PPO and HMO)** | **$5,098,458** | **60,944** |




Note: Premiums **include** LACERA's Administrative Fee of $8.00 per member, per plan, per month.

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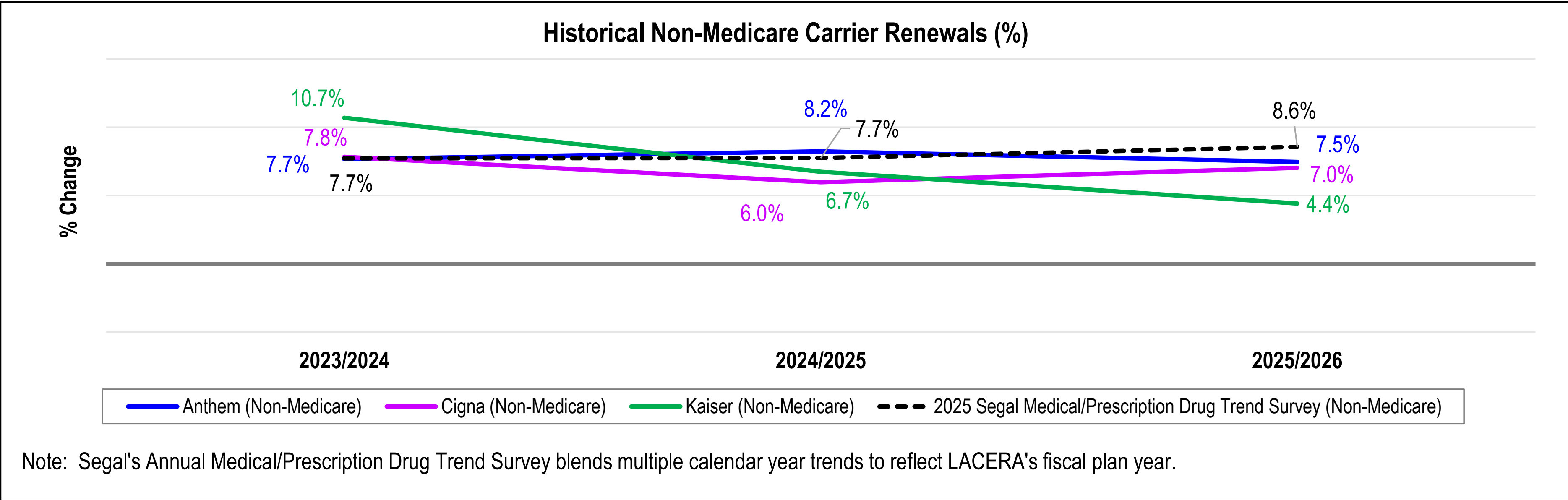
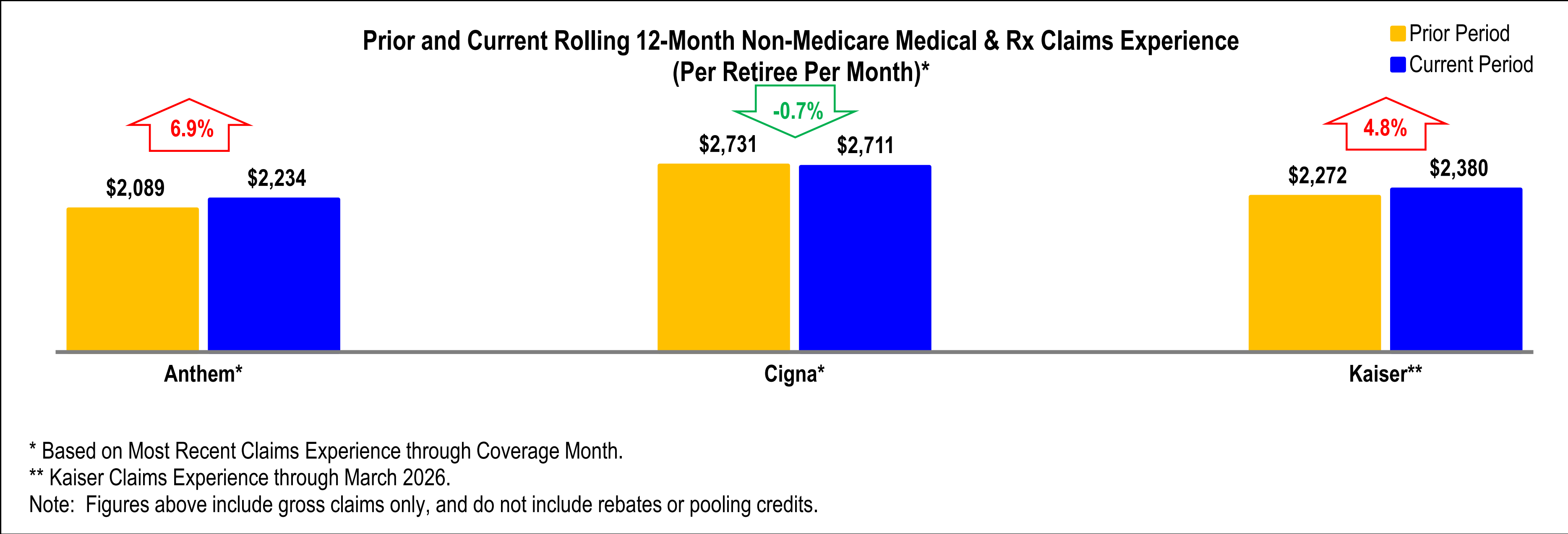
**Los Angeles County Employees Retirement Association**
Claims Experience by Carrier
*Coverage Month Ending May 2026*



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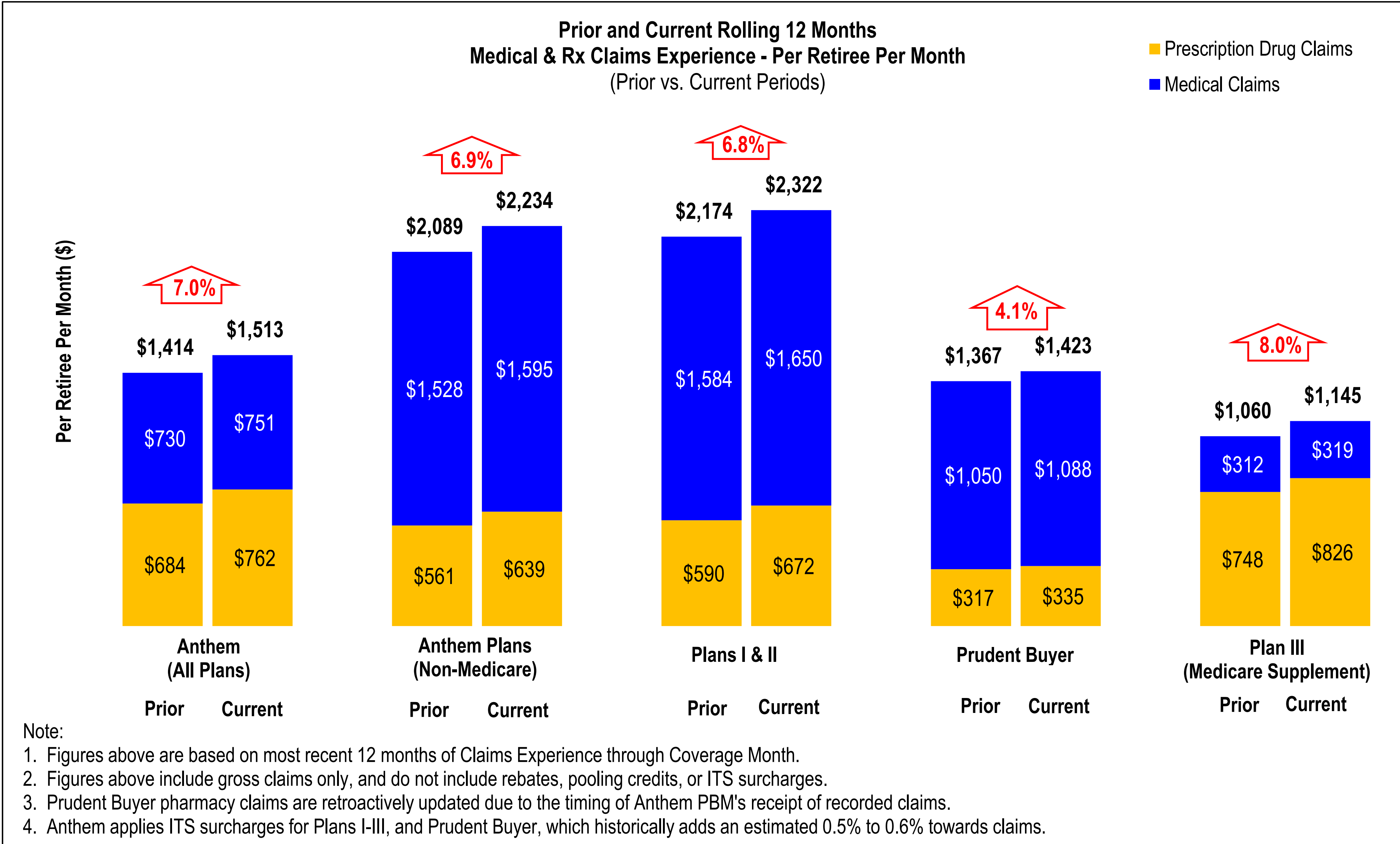
# Los Angeles County Employees Retirement Association

## Anthem Claims Experience By Plan

*Coverage Month Ending May 2026*




Note:
1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Figures above include gross claims only, and do not include rebates, pooling credits, or ITS surcharges.
3. Prudent Buyer pharmacy claims are retroactively updated due to the timing of Anthem PBM's receipt of recorded claims.
4. Anthem applies ITS surcharges for Plans I-III, and Prudent Buyer, which historically adds an estimated 0.5% to 0.6% towards claims.

| Blended (Medical & Rx) Trend | 2023/2024 | 2024/2025 | 2025/2026 |
|---|---|---|---|
| Non-Medicare (80% Medical / 20% Rx) | 7.7% | 7.7% | 8.6% |
| Medicare (20% Medical / 80% Rx) | 6.9% | 6.2% | 8.1% |

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# Los Angeles County Employees Retirement Association

## Kaiser Utilization

*Coverage Month Ending May 2026*

- Kaiser insures approximately 27,000 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in California.

| Category | Current Period 4/1/2025 - 3/31/2026 | Prior Period 4/1/2024 - 3/31/2025 | Change |
|---|---|---|---|
| **Average Contract Size** | **1.83** | **1.82** | **0.55%** |
| **Average Members** | **12,794** | **12,578** | **1.72%** |
| Inpatient Claims Per Member Per Month | $319.70 | $321.30 | -0.50% |
| Outpatient Claims Per Member Per Month | $581.14 | $548.03 | 6.04% |
| Pharmacy Per Member Per Month | $182.94 | $168.03 | 8.87% |
| Other Per Member Per Month | $218.83 | $212.54 | 2.96% |
| **Total Claims Per Member Per Month** | **$1,302.61** | **$1,249.90** | **4.22%** |
| | | | |
| **Total Paid Claims** | **$199,993,015** | **$188,661,915** | **6.01%** |
| Large Claims over $600,000 Pooling Point | | | |
| Number of Claims over Pooling Point | 11 | 5 | |
| Amount over Pooling Point | $2,874,054 | $427,516 | 572.27% |
| % of Total Paid Claims | **1.44%** | **0.23%** | |
| | | | |
| Inpatient Days / 1000 | 906.7 | 672.7 | 34.79% |
| Inpatient Admits / 1000 | 96.4 | 96.0 | 0.42% |
| Outpatient Visits / 1000 | 16,676.4 | 16,636.9 | 0.24% |
| Pharmacy Scripts Per Member Per Year | 14.2 | 14.1 | 0.71% |

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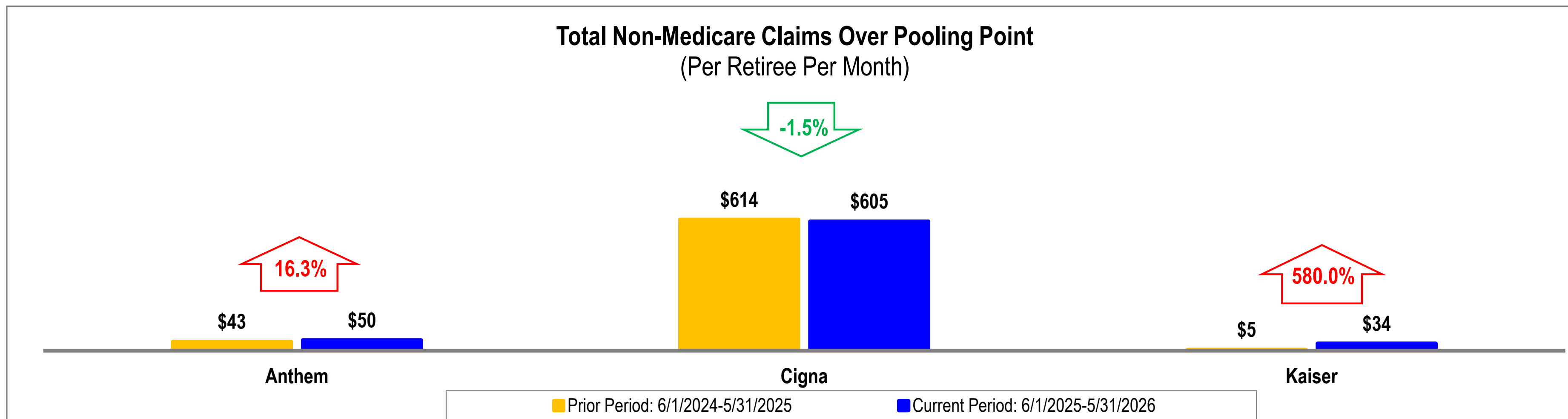
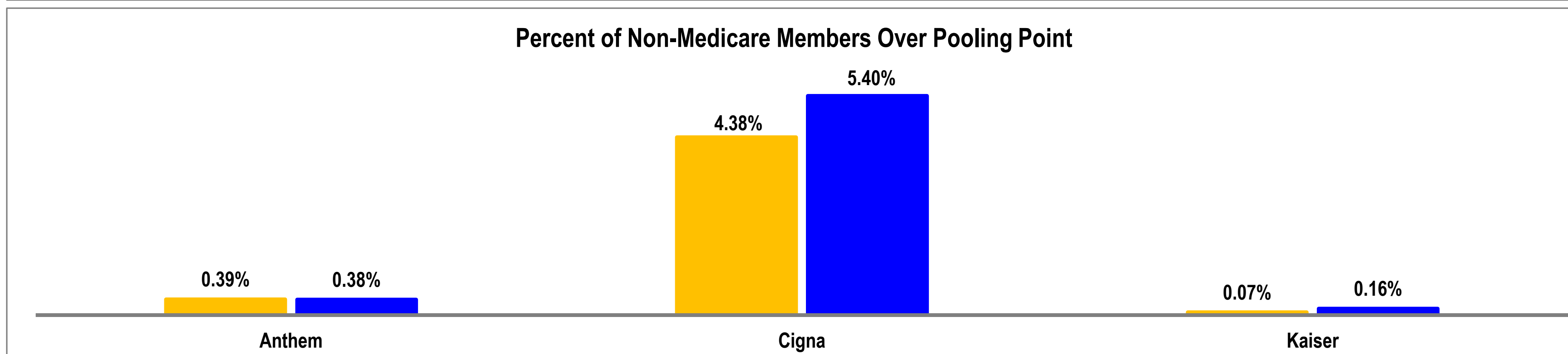
**Los Angeles County Employees Retirement Association**
High Cost Claimants (Anthem, Cigna, & Kaiser)
*Coverage Month Ending May 2026*




**<u>Stop-Loss & Pooling Points Overview:</u>**
Plan sponsors mitigate the financial risk associated with individual large claimants through reinsurance. Claims exceeding the specified individual pooling threshold are deducted from the carrier's renewal calculation. The pooling credit is offset by the carrier's pooling expense, which is applied to all policyholders.

Anthem and Cigna figures are based on the most recent Claims Experience through Coverage Month. Kaiser's figures are based on Claims Experience period between April through March.

**<u>Pooling Points by Carrier:</u>**
1. Anthem's pooling points are $400,000 for Plans I & II, and $300,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $600,000.

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# Los Angeles County Employees Retirement Association

## Anthem Lifetime Max Accumulation Status By Plan

*Coverage Month Ending May 2026*

| | Prior Calendar Year: December 2024 [1,2] | | | Current Calendar Year: December 2025 [3,4] | | |
|---|---|---|---|---|---|---|
| **Lifetime Claim Amount [5]** | **Plans I & II** | **Prudent Buyer** | **Combined** | **Plans I & II** | **Prudent Buyer** | **Combined** |
| $1.4M-$1.5M | 0 | 0 | **0** | 0 | 0 | **0** |
| $1.3M-$1.4M | 0 | 0 | **0** | 0 | 0 | **0** |
| $1.2M-$1.3M | 0 | 0 | **0** | 0 | 0 | **0** |
| $1.1M-$1.2M | 0 | 0 | **0** | 1 | 0 | **1** |
| $1.0M-$1.1M | 7 | 0 | **7** | 7 | 1 | **8** |
| $900K-$999K | 15 | 1 | **16** | 9 | 0 | **9** |
| $800K-$899K | 18 | 1 | **19** | 20 | 3 | **23** |
| **Total** | **40** | **2** | **42** | **37** | **4** | **41** |

| | Prior Month: April 2026 [3,6] | | | Most Recent Month: May 2026 [3,7] | | |
|---|---|---|---|---|---|---|
| **Lifetime Claim Amount [5]** | **Plans I & II** | **Prudent Buyer** | **Combined** | **Plans I & II** | **Prudent Buyer** | **Combined** |
| $1.4M-$1.5M | 0 | 0 | **0** | 0 | 0 | **0** |
| $1.3M-$1.4M | 0 | 0 | **0** | 0 | 0 | **0** |
| $1.2M-$1.3M | 0 | 0 | **0** | 0 | 0 | **0** |
| $1.1M-$1.2M | 2 | 0 | **2** | 2 | 0 | **2** |
| $1.0M-$1.1M | 7 | 0 | **7** | 9 | 0 | **9** |
| $900K-$999K | 9 | 1 | **10** | 9 | 0 | **9** |
| $800K-$899K | 23 | 3 | **26** | 24 | 4 | **28** |
| **Total** | **41** | **4** | **45** | **44** | **4** | **48** |

The number of members reported will fluctuate period to period due to multiple factors including migration from an Anthem plan to another LACERA-administered plan or members passing away.

[1] Includes two years of historical data.

[2] Based on data provided by Anthem on January 22, 2025.

[3] Includes two months of historical data.

[4] Based on data provided by Anthem on January 14, 2026.

[5] Members identified by Anthem as terminated were excluded from the counts above.

[6] Based on data provided by Anthem on May 18, 2026.

[7] Based on data provided by Anthem on June 17, 2026.

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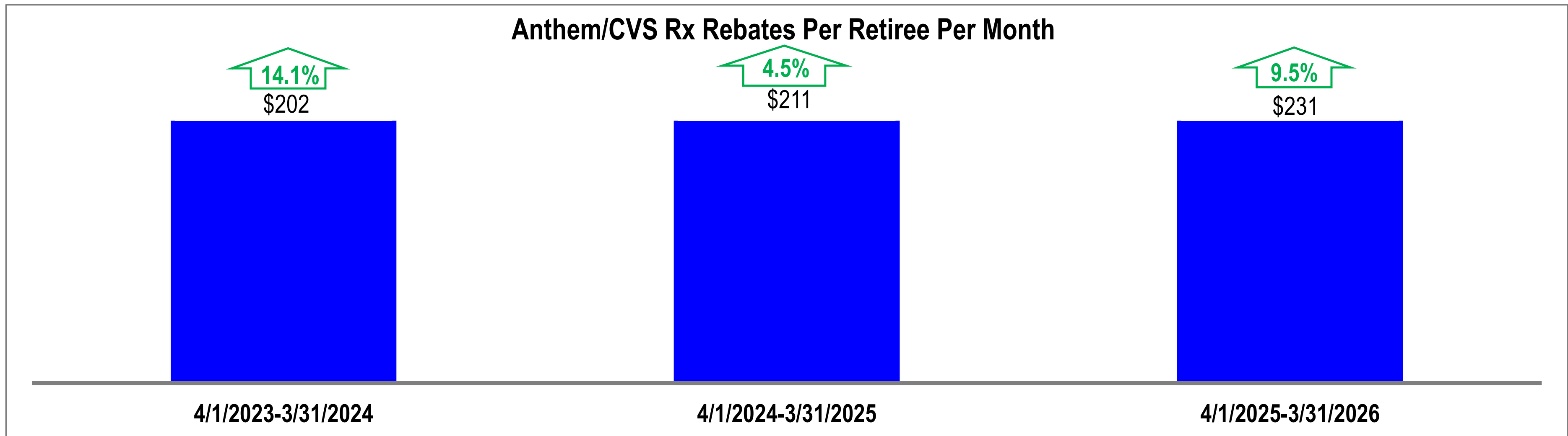
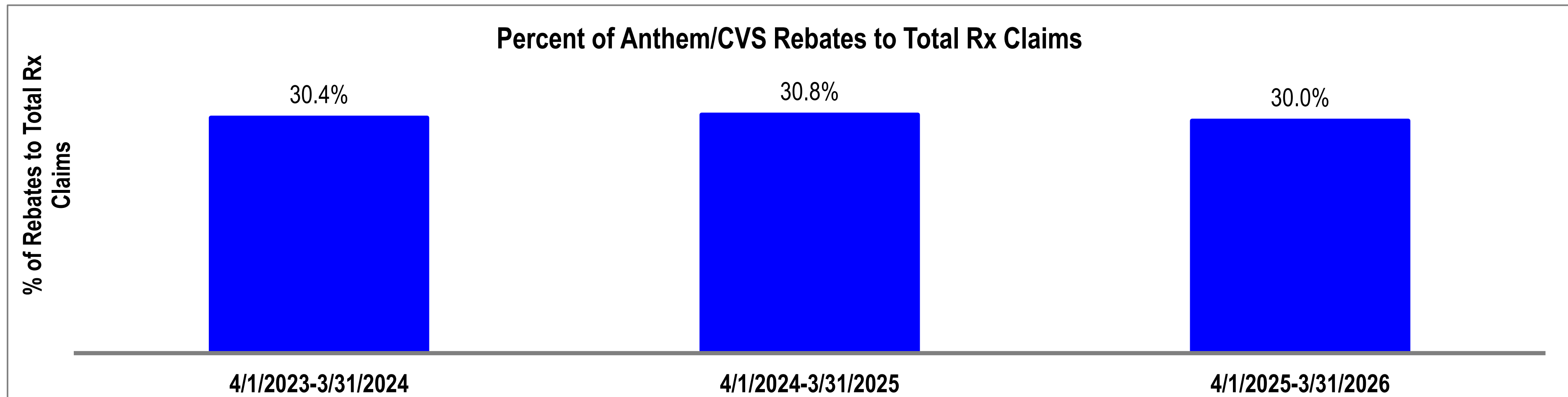
# Los Angeles County Employees Retirement Association

Prescription Drug Rebates (Anthem)

*Coverage Month Ending May 2026*




**Rebates Overview:**

Pharmacy Benefit Managers negotiate volume-based rebates with drug manufacturers of brand medications. Manufacturer rebates are passed on to plan sponsors and are used to offset pharmaceutical claims expenses.

**Note:**

1. Prescription Claims and Rebates Data were provided by CVS.
2. Anthem Prudent Buyer prescription drugs are provided by CarelonRx and are not included in the charts above.

# Los Angeles County Employees Retirement Association

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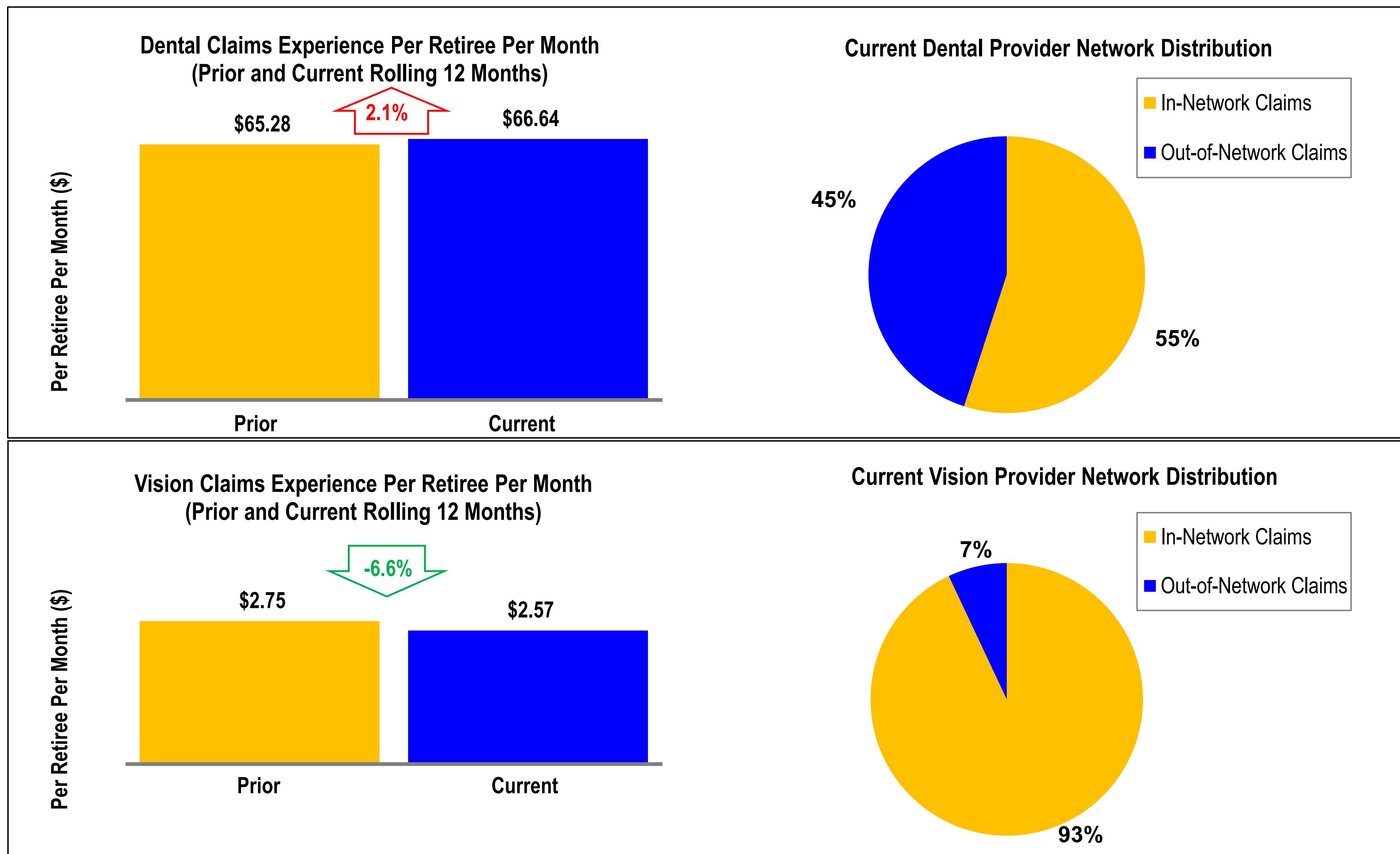
Cigna Dental & Vision Claims Experience

*Coverage Month Ending May 2026*




Notes:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Dental Claims Experience reflects passive use of Cigna's PPO Dental Network.

Segal

Compliance News | June 3, 2026

# Proposed Rule Promotes Fertility Benefits

The Departments of Labor, Health and Human Services, and Treasury (collectively, the Departments) recently issued a proposed rule that is intended to give group health plan sponsors greater flexibility in offering fertility benefits. Under the proposal, limited fertility benefits could be provided as excepted benefits under ERISA, the Public Health Service Act and the Internal Revenue Code, which would avoid the burden of having to comply with certain requirements, such as the ACA's mandate against lifetime limits on essential health benefits.

Limited excepted fertility benefits would include benefits substantially all of which are for the diagnosis, mitigation or treatment of infertility or infertility-related reproductive health conditions and are provided by medical professionals and subject to a total lifetime dollar limit per participant, together with their eligible beneficiaries, of $120,000 (adjusted for inflation).

The Departments propose that the rule would become applicable for plan years beginning on or after January 1, 2027. Comments are due July 13, 2026.

## Background on support for fertility benefits

The proposed rule advances the administration's priority to expand access to fertility benefits. In February 2025, the administration issued Executive Order 14216, "Expanding Access to In Vitro Fertilization," which sought to protect access to in vitro fertilization (IVF) and reduce costs for fertility treatment. (See our insight, "Executive Order on IVF.")

In November 2025, the Departments issued FAQs Part 72, which addressed how plan sponsors can use existing law to offer fertility benefits. For instance, FAQs Part 72 clarified that fertility benefits can be reimbursed through an excepted benefits HRA. (See our insight, "New Opportunities for Fertility Benefit Coverage.")

# The proposed rule on excepted fertility benefits

In the proposed rule published on May 13, 2026, the Departments would expand the category of limited excepted benefits to allow greater flexibility for plans to provide access to fertility benefits. The proposed rule provides detailed requirements, including notice requirements and examples. It also requests comments on, for example, whether an annual limit requirement would be preferred rather than a lifetime limit.

The Departments have previously addressed other limited excepted benefits, such as limited dental and vision benefits. Similarly, they are now proposing establishing specific requirements that must be met for fertility benefits to qualify as limited excepted fertility benefits. Specifically:

- Benefits must either (1) be provided under a separate policy, certificate or contract of insurance or (2) otherwise not be an integral part of a group health plan.
- Coverage must be limited to benefits substantially all of which are for the diagnosis, mitigation or treatment of infertility or infertility-related reproductive health conditions and are provided by medical professionals authorized to practice under applicable law.
- The total lifetime dollar limit per participant, together with their eligible beneficiaries, cannot exceed $120,000 (adjusted for inflation for plan years after 2028).
- The plan or insurer must provide written notice of the fertility benefit coverage to participants and eligible beneficiaries.

Note, a self-funded fertility benefit is not an integral part of a traditional group health plan offered by the same plan sponsor if the participants and beneficiaries who enroll in the self-funded fertility benefit can decline coverage under the sponsor's traditional group health plan. Thus, the plan sponsor offers both the traditional group health plan and the fertility benefits to participants and permits participants to enroll in either or both benefit options or decline to participate in either or both options for the plan year.

The proposed rule clarifies that fertility treatments include:

- Medications
- Surgery
- Intrauterine insemination
- IVF and other assisted reproductive technology
- Treatment of reproductive health conditions (e.g., polycystic ovary syndrome, endometriosis and uterine fibroids)
- Treatment of endocrinopathies (e.g., thyroid disorders)
- Treatment of primary ovarian disorders
- Treatment of male infertility disorders

The Departments acknowledge that the proposed excepted fertility benefits may include benefits that are covered by major medical plans and that in some instances coordination of benefits may be necessary.

## Proposed notice requirements

Written notice would have to be provided on the first date the participant or beneficiary is eligible to enroll in the limited excepted fertility benefit, annually thereafter and upon request. The notice must be written in manner expected to be understood by the average plan participant and must include the following content:

- A description of the coverage with a summary of benefits and limitations of the coverage (including the lifetime dollar amount limit established by the plan or insurer)
- How to identify and utilize a network provider, if applicable
- How to submit a claim for reimbursement, including whether the benefit uses the same claims procedure as for the sponsor's other group health plans

The notice would be sent to each participant's last known address and, if different, also to any eligible beneficiary's last known address. The rule emphasizes that the notice should be provided in manner expected to be understood by an average participant.

## Coordination with state law requirements

Requirements related to coverage of fertility benefits vary among state laws. Some states include fertility benefits as an essential health benefit (EHB) under the ACA. Under the ACA, non-grandfathered large insured and self-funded group health plans cannot impose lifetime and annual limits on the EHBs covered under the plan. For this purpose, self-funded plans select a state EHB benchmark plan to reference. Therefore, unlike the excepted benefit fertility benefit, a traditional group health plan relying on a state EHB benchmark that includes fertility benefits cannot impose a lifetime maximum on the fertility benefits offered under the plan.

In addition to state EHB laws, some states mandate certain fertility coverage through other laws. State laws may influence the fertility benefits that must be offered by an insured group health plan. While insured plans may be required to cover fertility benefits according to applicable state law, under the doctrine of preemption, such requirements generally do not apply to self-insured group health plans governed by ERISA.

The Departments recognize the existence of the range of state law implications. However, they suggest the limited excepted fertility benefit can be offered in a manner that ensures compliance with both state laws and federal law.

# Implications for sponsors of group health plans

Plan sponsors should watch for the final rule.

Until then, plan sponsors may wish to review their current fertility benefit offerings and consider whether to make any changes in light of the proposed rule.

Sponsors of group health plans can make fertility benefits available through the plan, through a limited excepted benefit arrangement, or both.

Plans that already offer fertility benefits through group health plan coverage may choose to evaluate whether they want to augment that coverage under the group health plan or through a self-funded or insured limited excepted fertility benefit.

While the rule allows flexibility for limited excepted benefits to include a broad range of fertility benefits, they can also be tailored to include specific benefits and can be offered at a lower lifetime amount than the amount in the proposed rule. Plan sponsors can consider what fertility benefit design might best complement benefits already available under the group health plan.

Plan sponsors that decide to offer limited excepted fertility benefits will need to ensure compliance with all aspects of the final rule once it is issued, including the specific notice requirements along with considering implications related to any relevant state laws.

This page is for informational purposes only and does not constitute legal, tax or investment advice. You are encouraged to discuss the issues raised here with your legal, tax and other advisors before determining how the issues apply to your specific situations.

Compliance News | June 5, 2026

# Final Rule on Independent Dispute Resolution Operations

The Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) along with the Office of Personnel Management (OPM) issued a final rule regarding the independent dispute resolution (IDR) operations under the No Surprises Act. The final rule aims to make improvements, particularly related to communications among group health plans and insurers, providers, and facilities with the certified IDR entities.

The final rule includes varying applicability dates ranging from August 3, 2026, the effective date of the regulation, to 90 days after the effective date, depending on the specific provision.

While the final rule is intended to improve IDR operations, it does not address other challenges.

## Background on IDR implementation

Most plans became subject to the No Surprises Act in 2022. The No Surprises Act prevents providers from balance billing patients who receive emergency services in the emergency department of a hospital, at an independent freestanding emergency department and from air ambulances. The law also protects patients who receive certain non-emergency services from an out-of-network provider at an in-network facility. (See our insight, "New Law Requires Transparency and Prohibits Surprise Billing" and "The No Surprises Act Requires Changes to Your Plan Coverage.")

The law established the federal IDR process, allowing for the negotiation for payment of out-of-network claims between payers and providers. In 2021, the Departments issued two interim final regulations in 2021, which included regulations regarding the qualifying payment amount (QPA) as well as initial regulations regarding the IDR process. (See our webinar recording, "The No Surprises Act Independent Dispute Resolution Process" and our insights, "Guidance on the No Surprises Act's Qualifying Payment Amount" and "No Surprises Act Rule on 2022 Independent Dispute Resolution.")

In 2023, the Departments issued two proposed rules on IDR operations generally, one regarding fees and one regarding operations.

Since its implementation in 2022, the IDR process has faced legal and implementation challenges including litigation related to the qualifying payment amount (QPA) calculation, a higher volume of claims submitted for IDR than was anticipated by regulators, as well as functional difficulties related to the administration of the IDR process through the federal portal. In response to the QPA litigation, the Departments issued enforcement discretion which was originally provided in FAQs Part 62 and extended through FAQs Part 67, 69, 71 and most recently set 73 published in April 2026. (See our insight, "Continue No Surprises Act Compliance Despite Court Decision.")

The final rule does not address the QPA calculation or enforcement approach. Further, as implementation has progressed, new challenges have surfaced, including potential provider abuse of the IDR process in some circumstances. The final rule does not address policy issues related to those challenges.

# The final rule on IDR includes procedural changes

The final rule focuses on operational improvements and specifically finalizes rules related to claims adjudication communications, open negotiations, batching, eligibility determinations, administrative fees and other procedural requirements. The guidance, which was published in the June 4, 2026 *Federal Register*, is aimed at standardizing the IDR process in a manner intended to reduce delays and costs and increase efficiency, including lowering the number of ineligible claims entering the system and facilitating the proper handling of claims by the responsible entity. The following changes are applicable August 3, 2026, unless otherwise noted.

## Changes related to payer communications and IDR registration

The Departments are working to create standardization early in the claims process. Specifically, under the rule, payers must use specific claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) when they provide any paper or electronic remittance advice to an entity that does not have a contractual relationship with the payer. The Departments indicate that they will establish an applicability date for the use of CARCs or RARCs through guidance posted on the DOL websites by December 4, 2026. It is anticipated that such guidance will provide regulated entities no less than four months to come into compliance.

The final rule addresses certain disclosures that must be shared with respect to the qualified payment amount (QPA) if the recognized amount for an item or service is the QPA. Plans and insurers must make certain disclosures about the QPA with each initial payment or notice of denial of payment and must also provide certain additional information upon request. These provisions will apply to disclosures required to be provided on or after August 3, 2026.

Further, any payer subject to the No Surprises Act must now register with the Departments and will receive a registration number, which must be be included with an initial payment or notice of denial of payment, as well as in subsequent notices. Registration-related requirements will be applicable 90 business days after the Departments issue guidance announcing that the functionality supporting the registry provisions has become available.

Generally, along with the registration ID, the rule aims to improve inclusion of identifying information that will support the claims process and clarifies content requirements related to open negotiation notices, notices of open negotiation response, notices of IDR initiation and notices of IDR initiation response. Among other requirements, where applicable, plans and insurers must ensure the inclusion of the legal business name of the self-insured group health plan or insurer relevant to the claim.

## Changes to the open negotiation process

The Departments have introduced changes to establish a process for tracking open negotiation through the federal IDR portal in anticipation of initiation of a federal IDR process dispute and to promote transparency and meaningful engagement in the negotiations process.

As discussed above, under the final rule, payers must include a statement explaining that providers must notify the Departments to initiate open negotiation. A party must send an open negotiation notice to the other party and the Department through the federal IDR portal to initiate open negotiations. The Departments clarified that the 30-business-day open negotiation period begins on the day on which the party first submits the open negotiation notice, including the remittance advice.

In addition, a party to an open negotiation notice must now send an open negotiations response within 15 business days of receiving a complete notice. The final rule includes specific content requirements for the open negotiation notice, which should help better identify the entities involved. Pursuant to the final rule, open negotiations will run through the federal IDR portal and proprietary portals will not be used for the negotiation process. The provisions regarding the open negotiation notice, open negotiation response notice, notice of IDR initiation, and notice of IDR initiation response are applicable 90 days after the effective date or November 1, 2026.

## Eligibility and batching

The Departments are continuing to improve the IDR eligibility determination process. Under the final rule, certified IDR entities have five business days to make an eligibility determination.

When a certified IDR entity encounters an eligibility determination issue that requires additional data, it must notify both parties and the Departments within five days of receiving the assignment. In turn, each party must submit the requested proof within five days. If a party fails to provide the information within the time frame, the certified IDR entity will either decide the matter using only the existing information or dismiss the matter entirely, if necessary.

The rule aims to facilitate processing efficiency and discusses rules related to batching IDR claims. Under the rule, parties may batch up to 50 related services in a single IDR claim, provided the services all meet certain requirements. Batching is permitted to encourage efficiency and minimize cost and permitted in specific circumstances detailed in the regulation. The changes to the batching rules are applicable November 1, 2026.

### Fees and extensions

The cost of the IDR administration fee is reduced from $115 to $15 per party, per dispute. This fee change is effective for disputes initiated on or after June 11, 2026. The Departments codified existing guidance that if either party fails to pay the administrative fee or the IDR entity fee by the time the party's offer is due, that party's offer will not be considered received. The Departments plan to limit extensions in the IDR process to cases where "systematic delays in processing disputes" cause the delay.

## Implications for sponsors of group health plans

Sponsors of plans that directly administer their IDR process will need to ensure they comply with the new process requirements as of the various applicability dates. Those that rely on a third-party administrator (TPA) will want to monitor the TPA for compliance. These changes are likely to have an impact on the numbers of disputed claims filed as well as claims settled during open negotiation.

Although these changes will improve the process, the overall challenges group health plans presently face are still an issue. Sponsors of plans that rely on a TPA or insurer should request information regarding IDR claims under their plan to help determine if they are impacted by the unfavorable trends and to seek solutions to improve the plan's IDR negotiation outcomes.

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